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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A COMMUNITY DEVELOPMENT APPROACH TO NURSING EDUCATION IN NORTHERN NATIVE COMMUNITIES, submitted by Patricia M. Stewart in partial fulfilment of the requirements for the degree of Master of Arts in Community Development.

Date: 1985

DEDICATION

This thesis is dedicated to my husband, Fletcher,
with thanks and love
for his time, typing, support and
feedback during those times of reflection, and to
my children — Guy, Caitlin, and Benjamin, for
enduring those absences when Mum and Dad were at
the computer.

ABSTRACT

The purpose of this study is to explore the hypothesis that a community-based approach to nursing education in northern native communities has distinct advantages over an institution-based approach.

Both the state of health and health care delivery have long been problematic for northern native communities. The health of native peoples has been and remains the poorest of any group in Canada. The "medical model" of treatment of disease after it occurs has severe limitations in native communities.

It is consistent with the native movement towards local control that native communities seek to provide their own health services using their own personnel. This implies that they must also be concerned with education for their own nurses. The process of educating native nurses is seen not only as a strategy for changing an imposed health care delivery system but also as contributing to a larger strategy for developing communities from within.

The reflections throughout the thesis have been guided by the dialectical paradigm — that framework which seeks to understand change as the result of conflicting groups interacting over time and producing or synthesizing new social forms or constructs. The paradigm is applied to describe and explain the historical "underdevelopment" of native communities particularly as this process has affected health. It is also applied in a critique of institutional health structures and roles and their inherent contradictions. A trend is identified towards more community-based health services as a solution to these contradictions; nursing education is seen to have the potential to be a necessary part of this trend.

The methodology used for this thesis is one appropriate to the field of Community Development. It is based on an extensive review of the literature plus the author's immersion in both a native reserve community as a Community Health Nurse and a northern community college as a nursing Program Developer. The literature review covers Community Development in Canada and beyond, health services and education in Canada and the Third World, nursing education, local, legal and Indian history, political-historical developments in Canada particularly in government-native relations. It includes the author's reflections on actions and initiatives taken in both work situations — college and community health. It also includes reflections on the actions and programs of others, especially case studies of a number of native-oriented nursing education programs. In other words, the methodology reflects the author's own praxis.

Finally, conclusions are drawn and recommendations are made for future endeavour in this field, focusing on the role of the change agent.

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I would like to thank Professor Marilyn Assheton-Smith, my thesis supervisor and teacher, who epitomizes the confidence and concern for her students that gives a university the depth and humanity so necessary to make it a community of scholars. She went beyond duty to enable this long-distance student to finish this program of studies; without her assistance and guidance this goal could not have been achieved. I would also like to thank the Boreal Institute for its assistance in financing some field work, the other committee members -- Amy Zelmer and Michael Asch -- for their valuable critiques and interest, and fellow students in the Division of Community Development, who made it such an interesting program of study. Finally, thanks is due to the Kelsey School Division for access to their computing facilities, a concrete example of community access.

TABLE OF CONTENTS

INTRODUCTION p. 1

Purpose and Problem p. 1

Definitions p. 6

Context and Significance p. 8

Methodology p. 10

Limitations p. 12

CHAPTER I: COMMUNITY DEVELOPMENT: PARADIGM, THEORY AND METHOD p. 14

Community Development as Social Change p. 14

The Historical-Structural or Dialectical Paradigm p. 14

Social Construction p. 15

Totality p. 16

Contradiction p. 17

Praxis p. 17

The Metropole-Hinterland p. 18

Relevance to Community Development p. 19

Selection of a Community Development Methodology p. 23

Action Research p. 28

CHAPTER II: THE NATIVE CONTEXT p. 30

History of Underdevelopment p. 30

Application of the Metropole/Hinterland Concept p. 30

The Treaties p. 35

The "Medicine Chest" p. 36

Reflection p. 38

Native Health p. 40
Early Observations of Native Health p. 40
Underdevelopment and Nutrition p. 41
Underdevelopment and Environment p. 45
Underdevelopment and Cultural Conflict p. 48
Underdevelopment and Economic Dependency p. 50
Strengths of the Community: Community Praxis p. 52
Reflection p. 55
Health Structures, Programs, and Services p. 56
Personnel Problems p. 56
Local Health Structures p. 60
The Pas Reserve p. 63
History p. 63
Natural and Human Resources p. 66
Culture and Heritage p. 69
Implications for Nursing Education p. 70
CHAPTER III: COMMUNITY DEVELOPMENT THEMES IN HEALTH DELIVERY AND NURSING EDUCATION p. 72
Towards a Definition of Health p. 72
Historical Development in Canadian Nursing Education p. 75
Early Development p. 75
Cultural Change and Contradiction in Nursing Education p. 77
The New Situation p. 80
Profession or Paraprofession p. 83
Contradiction in the Health Care Delivery System p. 85

Community-Based Approaches to Health Care Delivery p. 94
International Level p. 94
National Level: Hastings Report p. 98
Local Level: Klinic p. 99
Health Care and Community Development p. 100
Community-based Approaches to Nursing and Nursing Education p. 104
Community Health in Nursing Curricula p. 104
Nursing Education and the Sub-culture of the Community p. 107
Community-based Learning Experiences p. 108
CD Approaches to Education: BUNTEP p. 110
Evaluation p. 112
Criteria for Nursing Education p. 114
The Historical Trend p. 117
CHAPTER IV: CASE STUDIES p. 120
Introduction p. 120
Manitoba Cases p. 121
Attempted Program at Keewatin Community College (The Pas) p. 125
Further Proposals in Northern Manitoba p. 128
Mature Student Program (Brandon) p. 129
Inner City Nursing Project (Winnipeg) p. 131
Northern Nursing Education Program (Thompson) p. 133
Blue Quills/Grant MacEwan Community College p. 133
Oglala Sioux Community College (South Dakota) p. 136
Navajo Community College (Arizona) p. 139

Classification: Community-based or Institution-based p. 142
General Comparison of the Case Studies p. 145
Administrative Resources p. 145
Human Resources p. 146
Educational Resources p. 146
Material Resources p. 147
Evaluation: Relevance, Relatedness and Accountability p. 148
Brandon Program p. 149
Inner City Nursing Project (Winnipeg) p. 150
Thompson Program p. 152
Blue Quills Community College p. 154
Oglala Sioux Community College p. 156
Navajo Community College p. 158
Summary Evaluation of Cases p. 161
Reflections and Assumptions p. 162
CHAPTER V: SUMMARY, ANALYSIS AND CONCLUSIONS p. 164
Summary p. 164
Thesis Provisionally Demonstrated p. 166
Methodological Questions p. 168
Recommendations p. 169
Administration p. 169
Curriculum, Pedagogy and Practice p. 170
Selection p. 173
Staff p. 174

Reflection on the Dialectical Paradigm p. 175

Social Construction p. 175

Totality p. 177

Contradiction p. 178

Praxis p. 179

The Role of the Community Development Agent p. 179

BIBLIOGRAPHY p. 182

LIST OF FIGURES

Figure 1. Chart of Treaties p. 34

Figure 2. Graph Comparison of Remote Reserves p. 46

Figure 3. Table 1: Practicing Registered Nurses p. 122

Figure 4. Table 2: Bachelor of Nursing Graduates p. 122

Figure 5. Table: Community-based .....Institution-based p. 148

Figure 6. Table: Summary Evaluation of Cases p. 161

INTRODUCTION

Purpose and Problem

The problem in health care delivery faced by northern native communities can be described in terms of high incidence of health problems, shortages of nursing staff, unsuitable nursing education, and low recruitment of native staff to care for their own people. The purpose of this study is to explore the hypothesis that a community-based approach to nursing education in northern native communities has distinct advantages over an institution-based approach in meeting this set of problems.

It will be necessary in this introduction to describe briefly the current situation vis a vis health status and health care delivery in northern native communities, to develop inital explanations of key terms in the above statement of purpose (community-based, institution-based, nursing education) and to establish the significance of the overall problem. The exploration will proceed to a systematic description of an appropriate theoretical and methodological framework. A statement of the limitations of this study will conclude this introductory section.

The state of health and health care delivery have both long been problematic for northern native communities. Although it will later be shown that this is largely a post-contact phenomenon, the health of native people has been one of the apparent contradictions in a wealthy, industrialized society such as Canada. No matter what indicator is taken (infant mortality rates or crude death rates, morbidity rates or psychological indicators such as suicide, homicide and depression) the health of native peoples has been the poorest of

any group in Canada (Indian Affairs and Northern Development: 1980).

The Canadian response to this state of ill health has been a health care delivery system which, like other social institutions, has largely come to native communities as outside intervention. Doctors, nurses, hospitals for acute and chronic care, and professional and institutional specializations, characterize a system of health and health care designed by and for an outside and alien structure to "meet the health needs" of the native people. Not only has this structure been designed by outside forces, it has been almost totally staffed by outsiders, trained in institutions related to that alien structure.

The author's assumption is that government health bureaucracies and educational institutions operate in such a way that authority and power are dispensed and regulated from the top of a hierarchical pyramid structure. These regulatory bodies may provide accountability to the public for spending and quality control. On the other hand they may impede development at the community level. In contrast, the assumption of community development (and the author) is that decisions and actions are most effective in meeting human needs when initiated and implemented at the community level. In general terms, the change required to implement a community development approach is one in which the community exercises its organizational and political power to reverse an authoritarian process. This is in keeping with the goals of native self-determination and self-government.

The movement of native peoples towards self-determination during the last two decades has raised questions about human resource development in their communities, and about training their own people to manage their own affairs. But more particularly, this movement has been towards local control and reconstruction of heretofore imposed services and institutions. The purposes, methods, goals, and even underlying knowledge systems of these services, are challenged.

Raymond Obomsawin, speaking from a native point of view, challenges the "medical model" as a knowledge system that prevents communities from dealing with the real causes of their poor health:

> The conventional medical view that disease is a result of bacterial invasion is but a medical half-truth that has for decades conveniently allowed politicians and physicians to side-step more controversial issues in health and disease. As long as the "enemy" is a mere germ one can wage wars against disease using vaccines and drugs as tools, and never really have to change prevailing social, political and economic injustices that are in fact the underlying causes of disease. Behind the obvious signs of human disease lie many more fundamental issues not traditionally considered part of "health care": political self-determination, distribution of wealth and natural resources, food production, quality of education. All of these directly affect health (Obomsawin: 1983:189).

The limits of externally controlled intervention, based on the medical model, are even recognized in some government circles, as evidenced in the following quotation:

> It has become apparent that government's efforts to improve the health of Indian people are no longer having the desired effect. Our standard medical tools do not seem to address the problems of high hospitalization rates, violence, anti-social behaviour, suicide -- all indices of an accelerating crisis of health and social breakdown . . . However, not only is health status unimproved by today's standards, the situation is incompatible with both the aspirations of the Indian people and the tenets of

> self-determination and human rights. It has contributed to a deep-rooted passivity vis-a-vis the health services which has almost destroyed the interest of the Indian people in providing for their own health needs (Medical Services Branch: 1979:45).

This convergence of government and native points of view conveys a common sense that the "medical model" is severely limited in delivering health services to native communities. Even the concept of "delivering" health services reflects the importation of an external service. This thesis maintains that a more helpful model is the development of health care and its associated educational programs from within the community rather than delivery of these to the community. This follows the direction of thinking in the nursing field towards a self-care model (Orem: 1971, and Kinlein: 1977). Any strategy of change in the health care system will have to recognize and address the political, economic, social and educational dimensions of health care issues within native communities. These dimensions must be seen as part of a larger totality. This thesis will focus on the process of educating native nurses, not merely as a strategy for changing the health care delivery system, but as contributing to a larger strategy for developing communities from within in every dimension.

Nursing is but one role in the health system, but it can be described as the backbone of health services in the North (Wieler: 1971:333) and is therefore a significant point for change. With appropriate preparation, native nurses would be in a position to promote change in their own communities. It has been noted that education sometimes produces an educated elite who do not return to their community or contribute to its development. It is the

assumption of this thesis that a community-based approach to nursing education will counter-act this tendency. Nursing, seen in its larger totality, can provide a development path not only for native individuals, but, inasmuch as the process is grounded in the community, for the community itself.

The importance of grounding the preparation of health care workers in the community was partially recognized in the 1960s by the federal Medical Services Branch in training Community Health Workers to work in native communities as part of a community development strategy (Martens: 1969:1). Now called Community Health Representatives (CHRs), these workers partially fill the need for appropriate, accessible, indigenous health personnel. They have demonstrated the value of close-to-home learning opportunities in health services over the past two decades. CHRs are selected by their own communities to be local health resource people. As representative of the community, they have at heart the language, cultural understandings, goals and aspirations of the community. They have acted as mediators and interpreters of a foreign or alien health service to their own people and have mediated their people's needs to the professional health providers. They have also acted as health educators, environment officers, first-aid administrators, and liaison with their political representatives.

Approximately 1700 Community Health Representatives (CHRs), or lay dispensers, now work in native communities throughout Canada. Most, but not all, have a nurse or nurses also working in the community to call on for advice or assistance. Most are paid by their local band council or community (through a Contributions Agreement with the

Medical Services Branch) but some are directly employed by Health and Welfare Canada (HWC). The CHR program is now undergoing an evaluation by HWC.

People who have seen the program in action believe the evaluation will be favourable but there is general agreement that it does not go far enough. A senior advisor at HWC commented in 1983 to a conference of Indian and Inuit Nurses of Canada: "The thrust on getting more native people into health careers and educational up-grading is critical" (Stewart: 1984:36). He pointed out that in order to have the same ratio of nurses to population as exists in the rest of Canada, it would would be necessary to educate 3000 more native nurses.

To date, most of the efforts to provide a community thrust to health care in the North have centred on the provision of training and assistance to paraprofessionals. It is consistent with the native movement towards local control, that native communities seek to provide their own health services using their own health personnel at all levels. This implies that they must also be concerned with education for their own nurses.

Definitions

Nursing education is defined as a teaching-learning process whereby students attain the knowledge, skills and attitudes required to practice nursing. Nursing is a process whereby a nurse assesses the health needs of patients, and the patients' ability to meet their needs, develops a plan of care or action, and implements this plan, evaluating continuously the extent to which the client's needs are being met.

> Nursing in its broadest sense is caring. The practice of the profession of nursing is defined as those functions which, in collaboration with the clientele and other health workers, have as their objective, promotion of health, prevention of illness, alleviation of suffering, restoration of health, and maximization of health capabilities (Joint Ministerial Task Force on Nursing Education in Manitoba: 1977:4).

The term client or patient denotes a basic unit or situation to which a nurse responds by providing nursing care; this basic unit may be a person, family, group, ward unit, community or country (Allen: 1977:11). In northern native communities all of these "nursing units" (except "country") are present as potential clients. Thus nursing education could address the preparation of health workers to deal with all such units in the northern native context.

Nursing education should also have relevance to the society in which it is located (CNA: 1978:6). In this work, relevance to society will be considered in terms of the particular community served. The development of nursing education, and criteria for assessing the relevance of particular nursing education programs, will be discussed more extensively in Chapter III. In Chapter IV, which describes existing or recently attempted native-oriented nursing education programs, cases will be compared to determine the extent to which they are community-based or institution-based.

The term "community-based" refers to an approach which seeks to develop a specific community in such a way that the common goals, feelings and interests of the people will enable and support development to meet their own needs. This includes the identification of local resources and strengths, and the acquisition of those resources which are not present in the community but which are seen as essential to meet their development needs. Locally-controlled

institutions may be amongst these local resources. Thus, a community-based approach to development is the utilization of the community's indigenous and acquired resources as a means to the community's own goals. Such an approach is commonly referred to as "Community Development".

The term "institution-based" in contrast to "community-based" refers to an approach in which the needs, goals and resources of a particular institution shape the formation, administration, accountability and evaluation of a program. The institution may be located in the local community, or it may be a larger institution of society with local delivery systems, but it is relatively independent of the local community. Perhaps nobody sets out to plan educational programs to meet the needs of an established institution, but it is not uncommon for these needs to determine to a preponderent degree what programs and types of programs will be offered by a particular institution. This will be exemplified by Keewatin Community College, discussed later (Chapter IV).

These two approaches represent "ideal types" as used in sociology since Weber, to define opposite poles of a dialectical continuum, which can be used to analyze particular case examples.

Context and Significance

> One of the greatest difficulties facing Indian and Metis people is, obviously, the lack of resource development, and the outright lack of funding support to become viable economically, and therefore, independent. One of the greatest concerns of the day is human resource devlopment. To put this bluntly, The Indian reserves and Metis communities lack and need desperately, professionally and technically trained Indian and Metis people -- that is, architects, doctors, nurses, professionally trained accountants, managers, lawyers, and so on. That is, in a short period of time, we must produce this expertise . . .

> We therefore challenge the nursing profession in introducing new concepts in its education. We challenge the health professionals to introduce new concepts in fighting the poor health of our people. We challenge the nursing professionals to increasingly be involved with the development of paraprofessionals in the field of health. We challenge the nursing profession to recognize local control of health. We challenge the nursing profession to support us in fighting for those resources which could enhance real health of our people. Within the training field . . . the nursing field has the potential of becoming most invaluable in support and development of education programs. By this we mean a partnership concept whereby Indian people are involved from the beginning of planning to its end (Joint Brief of the Manitoba Indian Brotherhood and the Manitoba Metis Federation to the Joint Ministerial Task Force on Nursing Education, Manitoba: 1977:1).

This statement by Manitoba native leaders summarizes the connection between Community Development as defined above, health, and nursing education. Nursing education, carried out in partnership with the local community, is seen as a valuable means towards development of human resources, not only to meet the urgent health needs of the communities under discussion, but as part of the overall development of viable, independent communities able to meet their own basic needs. There should be a reciprocal relationship between the needs of the community and a nursing education program, as described in the following statement:

> Ideally a nursing education programme is established in response to the health situation and to the needs for health and nursing services at a point in time and in relation to the attitudes of that particular community or country towards health goals, for example, prevailing knowledge, values, plans, and innovations. The goals and purposes of the programme are related to the function the graduates will perform, which is, in turn, related to the health problems of the country and the type of care and services that these problems demand. The extent to which the programme is responding to the needs of the community, indicators of which may be economic, educational, political, may be said to be indicative of the degree of relevance of the programme (Allen: 1977:10).

It is proposed here that a Community Development approach to nursing education would help overcome many of the problems in health care delivery alluded to before, and thus contribute to overall development of the community by: bridging cultural differences; building on existing knowledge, attitudes and skills; utilizing local resources; designing educational opportunities suited to the setting; developing personnel with long-term roots in the region; and designing training and employment opportunities around perceived needs and priorities, in cooperation with indigenous leadership; and, not least, placing an important service under more local control. The demonstration value of such a program in a particular community would be significant for other communities, as well as for other schools of nursing in other settings.

Methodology

This thesis is largely descriptive and exploratory in nature. The overall shape of the thesis is a "praxis", moving from observations, to analysis, to action and reflection, as used by Freire (1972:60). The observations have been made initially in an informal way by the author over the years of interacting with native people as a friend, and in the role of the developer of an aborted native nursing education programme, and in the role of nurse in a native community. These observations have led to the central hypothesis of this work, and have directed the choice of the theoretical framework as the most appropriate for understanding the present situation as a result of history. Nursing education is but one element in the development of health services, but insofar as it relates to the larger totality, it increases its impact not only on health, but on the larger community.

In Chapter I, the theoretical framework will be more fully described. The dialectical paradigm is selected as the theoretical framework most suitable for analyzing the development problems of northern native communities and the process of creating their own solutions. According to this view, development is action taken to resolve historically created contradiction. In the process of resolving the conflicts resulting from incompatible structures or roles, something new is created. The historical process which has created an underdeveloped hinterland in the north will be shown to require redress of the lop-sided relationship between the dominant society and native communities. Educational programs at the community level become part of the process of shifting resources of the health bureaucracy (as well as the educational bureaucracy) from the overdeveloped to the underdeveloped sector of society. Community development methodology will be described as action research or praxis.

The first set of large-scale observations and analysis in Chapter I will be followed by application of the paradigm to native communities in Chapter II , to describe and explain the historical "underdevelopment" of native communities, particularly as it has affected health. The Pas Reserve is described as an example of a single native community which displays that historical underdevelopment and associated health problems.

The focus in Chapter III shifts from native communities to health and educational institutions, structures and roles. The roles of health professionals are examined for contradictions, or for signs of change which might make it possible for them to respond to the

developmental process occurring in native communities. Health care delivery is observed to have internal contradictions which make it typically external and alien to the native community. However, a trend is identified towards more community-based health services as a solution to these contradictions. Nursing education has the potential to be part of this trend.

In fact, native organizations and nursing education have already collaborated to initiate actions in this direction, some cases of which will be described in Chapter IV. These cases generally are attempting to make nursing education accessible to native students. They provide concrete actions to be reflected upon in a process of praxis. They will be critiqued first on the basis of their tendency to be community- or institution-based, and secondly on the basis of criteria from the nursing discipline.

The concluding chapter draws together the implications for a community-based approach to nursing education. The extent to which the thesis has been demonstrated will be discussed. The usefulness of the dialectical paradigm will also be reflected upon in more general terms. Insights into the role of the change agent will be discussed.

Limitations

Community Development is necessarily an inter-disciplinary study from the academic point of view. It draws on knowledge from various fields, and as a process is applied to various types of problems in a variety of settings. The disciplines of sociology, anthropology, health, education, and nursing are drawn upon in this study, in so far as they bear on the particular problem under discussion. This places limitations, in a thesis of this size, on the depth to which any one

discipline can be explored. This is a practical study, and the major implications are of a practical nature.

Although case studies from a variety of places in North America are drawn upon, the author's focus of concern for community-based nursing education is northern Manitoba in the 1980's.

This study will not involve itself in building a curriculum model for a nursing education program, although reference will be made to the feasibility of doing so. Community Development will be discussed as a process applicable to the delivery of health care and the education of health professionals, in particular nursing education. Health and health care will be discussed extensively as a back-ground to the discussion of nursing education. Available data will be drawn from a variety of existing sources. Case studies and the author's direct observations as a participant-observer will provide original data. Survey methods have not been used to generate additional quantifiable data. The nursing education cases discussed have not yet reached a sufficient stage of maturity for final outcomes to be rigorously evaluated, but some provisional conclusions can be drawn.

CHAPTER I: COMMUNITY DEVELOPMENT: PARADIGM, THEORY AND METHOD

Community Development as Social Change

Community Development is a positive change, or strategy for change, emerging from within a community. The goals and direction, priorities, problems, solutions and resources in a process of community development are developed, articulated, and implemented by the people of the community themselves. A major distinction can be made between types of social change as either "transmitted" or "transforming" (Freire: 1974:151). Transmitted change is an evolutionary type of development without deliberate guidance or active decision-making, whereas transforming change is intentional development brought about by individuals or groups through conscious decision and action. These "types" of change indicate different methods of change, and development can be equated with the process or method by which change is created. Change lends itself to historical-structural or dialectical analysis. The history, problems, identity and resources of the community are used by its members as they reflect on their situation, make decisions, and take action. When community members engage in such a process, they shift from being the objects of transmitted change to becoming the actors or subjects of transforming change. Freire calls this whole process "praxis" (1974:111).

As indicated in the Introduction, the dialectical paradigm seems most appropriate for analysis of the underdevelopment of northern native communities, and their potential for change.

The Historical-Structural or Dialectical Paradigm

Briefly, the dialectical approach is a "sociological perspective based on historical-structural analysis" (Coulson and Riddell: 1970:3)

which examines relationships amongst groups as they interact over time. In the theory of science, the term paradigm is used to refer to an overall perspective or world-view which characterizes the whole scientific synthesis at a certain stage of development.

The dialectical paradigm is chosen as the most appropriate theoretical framework within which to consider possibilities of dynamic social change. The dialectical view is a general perspective on social life. Its commitment is to understand the process whereby social arrangements are transformed into new patterns of relationship through the dissolution of old patterns and the emergence of new ones.

Some features of the dialectical paradigm will be described in keeping with Benson (1977:2): social construction or production; totality; contradiction; and praxis. This will be supplemented by Davis' (1967) discussion of the metropolitan/hinterland polarity.

According to the dialectical paradigm, social structures are produced by society itself, are part of a larger dynamic totality, and are changed in a dynamic historical process of resolving contradictions within the social structure through a cycle of action/reflection referred to as praxis.

Social Construction refers to the above production of social structures and relations through human interaction:

> Relationships are formed, roles are constructed, institutions are built, from the encounters and confrontations of people in their daily round of life. Their production of social structure is itself guided and constrained by the context. (Benson: 1977:3).

Social structures, in other words, are not a given of nature, but

are produced by the members of a society itself, either consciously or unconsciously. In this study, the societal arrangements of native people, understood as an underclass in relation to the dominant class and culture , will be analyzed as the social product of their joint history or history of interaction. The state of poor health evident in this group will be shown to be a consequence of their historical relationship to the dominant society, and as a contradiction of the social goals of universal health care. For this work aspects of the construction of the health care delivery system and the post-secondary educational opportunities in the North for native populations will be described, with concrete reference to The Pas, Manitoba. It will become evident that the local educational institution has provided a significant obstacle to the implementation of appropriate nursing education in The Pas.

Totality is a principle that requires that a community see itself both as a whole in itself, and as a part of a greater wholeness, to paraphrase Freire (1974:133).

> The principle of totality expresses a commitment to study social arrangements as complex interrelated wholes with partially autonomous parts. The totality includes newly emerging social arrangements as well as those already in place (Benson: 1977:4).

Thus native communities can be studied within their historical context as a hinterland in relation to the dominant metropolitan society. Particular dimensions of these communities must not be seen in isolation from one another. In this work health care will be examined as an exemplary part of a more complex totality, rather than

in isolation from other aspects of the social structure. This thesis will explore such relationships as the place of health institutions and educational institutions in the community, evolving professional and male/female role relations in health care structures and in native communities, and the underdevelopment of native health in the dominant society, with the objective of seeing more clearly the potential of a community-based nursing education program.

Contradiction refers to the incompatibilities, inconsistencies, and conflicts formed in the process of social construction, thereby producing the seeds for breaks in the existing pattern:

> Analysis pursues the breaks of the social structure which occasion divergent, incompatible productions, and the relations of dominance between sectors or layers of the social structure (Benson: 1977:4).

Such "breaks" will be examined as "triggers" for social change, and clues to needs and directions for change. According to the dialectical paradigm, the hope lies in identifying the contradictions, or breaks in the social structure, and searching for resolution through a new synthesis, i.e., a new social construction. As with other principles presented here, the effects of contradiction will be observed particularly as they occur in relation to the health system; however, the principle of totality implies their occurence elsewhere in the historical development of The Pas Reserve, and this may need to be noted.

Praxis (Benson: 1977:6) refers to a process of reconstruction of social arrangements on the basis of reasoned analysis of both the limits and potentials of present forms. It is a practical,

problem-solving combination of analysis, action and reflection. This cycle can be entered at any point, and can be repeated, progressively refining analysis and action throughout a developmental process until an appropriate change has been achieved.

Out of conflict theory has been born a whole technique of praxis based on "conscientization" by such people as Paulo Freire (1972:15). This is an integration of theory and practice at the grass-roots level to increase a people's critical understanding about their relationship to the world. In the introductory remarks of this chapter, this conscious, intentional action and reflection was put forward as community development method which produces transforming change, not only in individuals but in their social relations and structures. This approach aims at creating a critical consciousness through reflection (i.e., evaluating experience of events, structures, and the exercise of class power), action (i.e., defining alternative goals and taking action to realize them), and further reflection (i.e., critically assessing the action taken, and thereby modifying continuing understanding and goals in an on-going process). Clearly, such a process of active social construction could be applied to health-care development in communities.

The Metropole/Hinterland polarity describes a particular structural product of the historical process of underdevelopment. The contradiction of unequal and dependent development tends to assume geographic proportions or a spatial dimension. The natural, financial, and human resources of hinterland regions or nations are channelled to a dominant centre, or metropole, with the effect of distorting and limiting the hinterland's productive forces to match

the needs of the metropole. Underdevelopment is actually a product of development in the metropole. As Frank has shown, in a careful analysis of underdevelopment in Latin America,

> . . . underdevelopment is not due to the survival of archaic institutions and the existence of capital shortage in regions that have remained isolated from the stream of world history. On the contrary, underdevelopment was and still is generated by the very same historical process which also generated economic development, the development of capitalism itself (Frank: 1966:9).

The same process which promotes the accumulation and concentration of wealth in the metropolis, promotes the dependence and underdevelopment of the hinterland. This process occurs both between nations, and between regions within nations. The metropolis/ hinterland concept can be used to describe the relationship of a dominant, geographically-located interest-group acting on a weaker party in a self-interested manner. On a global level, this has been enacted historically in a process referred to as colonialism. The interaction has produced overdevelopment in one sphere (the colonizing nations, or imperial powers) and underdevelopment in the colonized sphere. Within Canada, northern resource areas constitute a hinterland, and Indian reserves have been "underdeveloped" as dependent areas according to this model.

Relevance to Community Development

The relevance of the dialectical approach to Community Development must now be considered in more detail. A community development worker should have an understanding of the dynamics of conflict, and of the

actual conflicting forces in Canada, in order to assist groups worked with to analyze their position within the whole framework of Canadian society, identifying causes, solutions, enemies and allies.

When an "underdeveloped" group moves towards "development" -- that is, identifying themselves as a community of interest, articulating common goals, and taking action to achieve those goals with increasing confidence -- they can expect conflict and opposition from those in whose interest they remain underdeveloped. Conflict theory is an essential tool in coping with this hard fact of life.

According to George Manuel, past president of the National Indian Brotherhood, "as long as there is somebody around the community keeping everybody's mind moving toward a goal, then community development is happening" (Manuel: 1974:127). Reflecting on his own community development experience, he wrote: "Every field worker who was sent out had to decide whether he was there to sell his Indian community on the solutions for which the government wanted to find acceptance, or whether he was there to serve the community, and help it find ways to give voice to its own felt needs" (Manuel: 1974:129). In this kind of bind, the community development worker must expect to be caught in conflict, and must choose with whom to work, and towards whose ends. In fact, to choose the government's solutions is not to do Community Development at all.

Denis Goulet stresses the need for value-clarification when pushing change in a certain direction. He criticizes "palliative incrementalism which obstructs . . . through solutions . . . which delude people into thinking problems have been really met when in fact they have only been disguised" (1971:294-298) . The alternative to

this is a "genuine gradualism" which creates new possibilities. This gradualism can be distinguished by three criteria: a direction that reveals connections and goals for universal development; the meeting of priority needs; and human fulfilment in a non-elitist manner. This rules out changes programmed by a vanguard, elite, or group of experts. The style in which change is carried out is important, since this demands that change agents restrain their own goals to work in a direction that does not impede the just rights of others, and that reflects the values and needs of their priorities (that is, their goals should not undermine their basic identity.)

The Canadian ethos involves an acceptance that reform takes time, and a willingness to provide social services such as Medicare, Canada Pension Plan, etc. This latter thrust has come from various populist movements such as alliances of farmers and labourers in Saskatchewan, through the C.C.F., and later the N.D.P. Although electoral politics has sometimes blurred its distinctiveness, the N.D.P. provides the critical voice, the other pole of the dialectic, which attempts to point to the contradictions and to clarify choice based on an awareness of values in distinction from the dominant power of Canadian society -- the Liberal or Conservative Party. Other grass-roots organizations have taken shape outside the framework of the N.D.P., such as the Parti Quebecois, and native organizations. The Quebecois and the Natives are more directly confronting and articulating questions around economic and political democracy in Canada than any other groups. These two groups are self-aware "nations" with a consciousness of their vulnerability <u>vis a vis</u> the dominant culture. They have a long history of being unequal partners living in a

Canadian hinterland. Ironically, their obvious vulnerability is a kind of strength, since it contributes to a strong sense of identity and a willingness to struggle. Observers of the current struggles of these 'minority groups' see fundamental changes being demanded: "The pillars of the old structures of accomodation are crumbling" and "Indians are demanding a new accomodation be struck between themselves and the larger society" say Gibbins and Ponting (1980:334). There are already strong pressures to expand the scope and authority of local governments such as Bands and Tribal Councils. If the consciousness of a significant portion of the dominant culture could be raised in a similar manner, a challenge could be mounted against the establishment values of "development" at any cost.

A significant example of such rising awareness is provided by the willingness of the institutional churches and progressive unions to take a stand with native organizations on issues of land claims and northern development (Gibbons and Ponting: 1980:290). In the case of the churches, two causes can be identified: the existence of a powerful symbol-system at variance with many of the values of the secular culture; and a sense of common religious identity with specific native groups. In this way, people who have not been traditionally part of the "opposition" are being drawn into supporting oppressed groups. There is the potential for the dawning awareness that non-native problems are not very different from those of the native peoples.

Chief John Kelly, Treaty Three, addressing the Hart Inquiry, an Ontario Royal Commission on the Northern Environment:

> You may not share my spiritual anguish as I see the earth ravaged by the stranger, but you can no longer escape my fate as the soil turns barren and the rivers poison. Much against my will, and probably against yours, time and circumstance have put us in the same circle. And so I come not to plead with you to save me from the monstrous stranger of capitalist greed and technology, I come to inform you that my danger is your danger, and my genocide is your genocide (Jiles: 1978:5).

This then is the totality within which Community Development must take place. Contradictions become opportunities for change; structure and role conflicts point to where the change is occurring. Praxis becomes the work of creating the new -- the new understanding of our own value, the new role, the new relationship between human beings in a new social structure.

Selection of a Community Development Methodology

This chapter began with the dialectical paradigm as a useful framework for understanding the nature of social change. This section turns to the application of that theory in the practical discipline of Community Development as the practice of intentional social change. The chosen methodology is one of action research or praxis, that is, reflection on one's actions guided by dialectical theory. The author's reflections took place within a work context, first as an employee of a community college which was funded to develop a curriculum for a community-based nursing education program; and secondly as a nurse employed by The Pas Indian Band.

The question arises when the need for qualitative information, rather than quantitative information, becomes apparent. A Community Development type of question, such as "What do the people in the community want?" will not be answered by looking at existing

quantitative data sources, for example, census tracts, health statistics, crime rates, etc., although these will be useful in mapping the community. The methods of gathering this qualitative type of data, from a Community Development perspective, must be those methods in which development itself is encouraged within the actual research process; that is, research is a tool or instrument for development, not merely for acquisition of knowledge. Thus a participatory type of research becomes an inherent means for reaching the goal of development. This contributes to efficiency, in that research and development goals are then linked in a single, unified process of praxis, or action/reflection.

A further, fundamental question is not the selection of the problem so much as the perception or conceptualization of the problem. How problems are initially defined determines how they are selected. This is stressed by Margaret O'Neill Yoak, herself a Community Development practitioner: "Our conceptualization of a problem has vital implications for the solutions we undertake, and so our understanding of social and community structures will dictate methodologies in Community Development practice" (Yoak:1974:47).

In the body of this section, the question of how the method of doing research has indirect impact on the subject-matter being researched will be explored: the often unintended effects of the researcher's world-view will cause different approaches to problem definition, different understandings of the relationship of research and action, and on-going evaluation. Such a process cannot be initiated by a researcher alone, as it involves dialogue; it should be initiated by a native organization, or community group of some sort.

A fundamental factor affecting perception of a problem is the world-view of the individual or group defining it. One's own world-view, and how it operates in practice, is as difficult to examine as the back of one's own head. It is an essential framework which we carry inside us, through which we filter and interpret everything we encounter; but because of our socialization, this framework is so internalized that we are no longer conscious of it. The basic assumptions professionals bring to a research task will affect how they define the problem, what solutions they offer, and may well re-shape the nature of the project itself, especially if they are unaware of their own biases.

For example, if the philosophy of a Community Development worker is working "with" people rather than working "for" them, as expounded in T.R. Batten's non-directive approach (1974), then the "conceptualization of the problem" must be the task of the people in the community. Batten's approach is basically the stimulation of the people to consider both advantages and disadvantages of a proposed development in their area; the responsibility of the final decision rests with them.

It is often the case that an external CD worker is called upon after the problem has already been defined, and the people want some assistance in handling it: studying the problem, analyzing it into manageable portions, organizing to solve it. For example, a Chief and Band Council may hire someone to assist in developing economic opportunities on the reserve, or implementing the desire for better health or housing. The general problem has already been identified. But the worker may have to press the community to sharpen the

definition, and to be more conscious of how it was defined. On what observations was the identification based? What values, beliefs, priorities and world-view are reflected in the identification? This is part of seeing the problem in context, an understanding of which can contribute to a more real solution.

In this process, however, the worker runs the risk of substituting a completely different world-view from that of the community, redefining the nature of the problem, and arriving at a solution that does not "fit". In a case discussed elsewhere in this thesis (p. 160) a community college in the mid-North had identified a problem in health-care delivery to northern, especially native, communities. In cooperation with native groups, they began to plan towards a community-based nursing education program which would educate native nurses within their own cultural environment to meet the needs of their own people. However, the nursing establishment insisted on the curriculum design being carried out by a consultant who was trained in, and oriented towards, a traditional hospital-based approach to nursing education. The end result was a proposed curriculum which in no way resembled the original intention. It reinforced a traditional paradigm in the minds of nurses in the hospital and staff in the college, blinding them to the possibility of a more innovative approach. The reversion to the traditional model even resulted in a loss of funding for the program, since funding had been assembled on the basis of a Community Development concept. The northern native communities had been previously involved in community-based teacher education and wanted a similar model applied to nursing education.

The danger in the above model is what Freire calls a "focalist"

vision which concentrates narrowly on a single problem within the community; technical experts are frequently called into a community to advise on an isolated "technical" problem from what Freire calls a "problem-solving stance". "Merely to perceive reality partially deprives them of the possibility of a genuine action on reality" (Freire:1974:107). He contrasts this with what he calls "problematizing" in which community members analyze a problem themselves in their own terms, from their view of the totality or total context of the problem (p. 153).

Denis Goulet prefaces Freire's book thus:

> The goal . . . of all developmental change is to transform people, not merely to change structures. Freire's concern for people is so central that it rules out any policy, program or project which does not become truly theirs. The mark of a successful educator is not skill in persuasion — which is but an insidious form of propaganda — but the ability to dialogue with students in a mode of reciprocity. And rural extension fails as communication because it violates the dialectic of reciprocity; indeed no change agent or technical expert has the right to impose personal options on others (1974:xiii).

To illustrate: There is a story of a Canadian development worker sent to a community in India to help in building a well to provide a safe water supply. The people had resisted all efforts of previous workers to organize to work on the project. The latest worker met with the community, and instead of raising the subject of the well, asked them what they wanted to do. They explained that their burial ground needed a fence to prevent people trampling disrespectfully over it. The worker then assisted in carrying out this project. When the fence was complete, the leaders of the community approached him and asked him when he wanted to start work on the well.

Action Research

In research terms, "action research" comes closest to the process of action/reflection referred to as praxis. Donald Voth (1979:72) defines action research as "research used as a tool or technique, an integral part of the community or organization in all aspects of the research process, and has as its objectives the acquisition of valid information, action, and the enhancement of the problem-solving capabilities of the community or organization".

Regardless of what form the action research takes, the question remains, What is the relationship of the research activity to Community Development and/or the people living in the community? Like Freire's conscientizacion (1974:19) action research has as one of its goals "raising the consciousness" of the people, who develop from objects to subjects and agents in their own communities, developing a critical awareness, studying and shaping their own situation through democratic decision-making, action, and evaluation. This kind of process engenders transforming change and self-help skills which far outlast the particular research project.

Freire's approach is particularly relevant not only to research as such, but to the teaching/learning process, or "pedagogy", as a means of change. In such a pedagogy, teacher and learner are partners in seeking a critical understanding of social practice. Reading and writing also involves learning to 'read' the social reality being described. This suggests a more creative approach to "up-grading" literacy skills of nursing students, which typically takes an additional preparatory year for disadvantaged students, before they actually experience nursing actions or study nursing subjects. A

conscientizing approach would build up-grading into the learning process, using nursing practice and theory as the material for literacy practice.

Freire also discusses the theory of practice-reflection (praxis) as it extends to the "school". As the dichotomy of practice and theory is overcome in this method, so is the dichotomy of manual labour and intellectual labour in the schools. The school does not stand in opposition to the farm or factory. The school, i.e., the location where reflection or critical analysis occurs, can be located in the factory or on the farm. In the case of nursing education, the "school" would become the community setting or wherever nursing is practised.

There is a universal appeal to this pedagogy because of its underlying assumptions. Its effect is not to destroy a culture but to build, to grow or develop, on the culture's own strengths. It is a constructive kind of experience because it attempts to make the student conscious of reality with all its contradictions and provides a challenge to the creative dimension of the human spirit to cope with, to re-create, to synthesize, to give birth to desired changes. For Freire, the literacy program is just a tool or instrument to further the intentional development of a people. In like manner, such a pedagogy or research approach could prove useful in the development and implementation of a nursing program in native communities, enabling the self-development of the whole community.

CHAPTER II: THE NATIVE CONTEXT

History of Underdevelopment

Application of the Metropole/Hinterland Concept

The concept of underdevelopment as elaborated by Andre Gunther Frank in his analysis of Latin American society is useful for an understanding of the Canadian situation, allowing for a difference of degree. It is part of Frank's hypothesis that underdevelopment is a product of what the dominant metropole calls development. He elaborates to the effect that the regions which are most underdeveloped today are those which had the closest ties to the metropole in the past (Frank: 1966:13). This view may be confirmed by noting the example of the former Canadian "Northwest" -- the northern parts of the prairie provinces, whence came the original major raw resource for export from the New World to London, namely furs. By the time the Hudson Bay Company territory was transferred to Canada in 1870, the native people in the Northwest had already developed a degree of dependence on the European economy and culture, primarily through the trading relationship and the social patterns it produced. The new state's desire to expand and dominate or "open up" the West had already been felt by the northern native people. Contact in northern Manitoba was established about 1690 with the establishment of the Hudson Bay Company's Fort York on the coast of Hudson Bay, near the modern site of Churchill.

The Northwest Rebellion of 1869-70 was a manifestation of the conflicting view of and interest in the Land, as between the settlers and the native people. Control was being imposed by the new Canadian Government, (a) by setting in place the physical infrastructure of

railroads, land-surveys, etc. (b) by establishing social control, through the police (Northwest Mounted Police); and (c) formalizing transfer of control of the land through a series of numbered treaties, starting with Treaty #1 at Lower Fort Garry (1871).

The following characteristics describe the native people's weak position in relation to the Government at the time the treaties were being negotiated: (Development Education Centre: 1971:6)

1) Dependency on the HBC for firearms, ammunition and cooking utensils;

2) Alcohol-dependency was already a problem, as witness HBC policies attempting to control it.

3) Near extinction of the buffalo (decimated by American cavalry and hunters with the connivance of Upper Canadian politicians), and with the buffalo, the extinction of the social product of an economy and way of life based on the hunt; clearing the land of buffalo was seen as a necessary preparation for settling the land with farmers. The Swampy Cree in Northwestern Manitoba made an annual migration to the Saskatchewan plains to hunt buffalo, or to trade items they had previously obtained from the HBC for buffalo hides from the plains tribes. The extinction of the buffalo undermined this type of complex economic and social interaction within and between various Indian groups;

4) Uncertainty and suspicion based on the plains Indians' knowledge of the history of wars and broken treaties in the American West:

> Our chief difficulty was the apprehension that the hunting and fishing privileges were to be curtailed. The provision in the treaty under which ammunition and twine is to be furnished went far in the direction of quieting the fears of the Indians, for they admitted that it would be unreasonable to furnish the means of hunting and fishing if laws were to be enacted which would make hunting and fishing so restricted as to render it impossible to make a livelihood by such pursuits. But over and above the provision, we had to solemnly assure them that only such laws as to hunting and fishing as were in the interests of the Indians and were found necessary in order to protect the fish and fur-bearing animals would be made, and that they would be as free to hunt and fish after the treaty as they would be if they never entered into it (Cumming and Mickenberg: 1972:121).

5) Destruction of native health by epidemic spread of European diseases, especially smallpox: "In 1869 smallpox was transmitted from a Missouri River steamboat to the Indians of Montana and quickly spread northward. Before it was over, more than 3500 Indians and halfbreeds in the Canadian prairies were dead." (Graham-Cumming:1967) Native vulnerability to such diseases as smallpox and influenza has been well-documented. These epidemics spread in waves across the continent, decimating the native population and undermining their capacity to resist the European culture. There was nothing in native medicine to cope with these new diseases. Europeans had not yet developed active treatments, but were familiar with the Cowpox Syndrome, may have developed some level of biological resistance, and were well aware of hygenic and public-health measures such as hand-washing and quarantine. The missionaries were able to introduce some of these measures and thereby lessen the impact of the epidemics to some extent. It has been asserted that the transfer of disease was sometimes intentionally facilitated by the distribution of infected blankets to native people.

6) Future white settlement was presented as a fait accompli. Negotiating Treaty #1, Lieutenant Governor Archibald, after describing the Great Mother's concern for "the happiness and contentment of her red children" through reserving land for them, warned them that "irrespective of whether the treaty offered by the Government was accepted or rejected by the assembled Indians, the territory in question would be subject to white settlement". Cumming concludes: "The choice offered the Indians was either to reject the treaty and have their land settled by the whites or to accept the treaty on the terms offered by the Government and formally cede their land to the Crown" (Cumming and Mickenberg:122).

CHART OF TREATIES (Source: Cumming and Mickenberg: 1972:118)

The Post-Confederation "Numbered" Treaties

The Treaties

> During the primary treaty-making period Western Canada was undergoing very rapid changes and the Indians were experiencing widespread malnutrition, starvation, and disease (Cumming and Mickenberg:124).

A process of breakdown of native structures and institutions was already under way by the time negotiation of treaties began. As described in the preceding section, epidemic disease, alcohol dependency, and the extinction of the buffalo had begun the process of underdevelopment. The Indians were left with nothing but game hunting and fishing for subsistence. This is apparent in all the numbered treaties except #9 and #10, from native insistence that these rights be protected. As the commissioners for Treaty #8 state in their report:

> In 1870 it had been deemed necessary to despatch two agents to inform the Indians of the Government's intention to send troops to Red River, and to arrange with them a right of way through their country. In a pow-wow with Colonel Wolseley at Fort Frances, the Indian chief, Crooked Neck, refused to accept the presents offered him, gaudy red shirts, coats and caps, and declared, "Am I a pike to be caught with such a bait as that? Shall I sell my land for a bit of red cloth? We will let the pale-faces pass through our country, but we will sell them none of our land, nor have any of them to live amongst us." Other bands expressed similar views. "We believe what you tell us when you say that, in your land, the Indians have always been treated with clemency and justice . . . but do not bring settlers and surveyors amongst us, until a clear understanding has been arrived at, as to what our relations are to be in the time to come" (Cumming and Mickenberg:121).

Cumming and Mickenberg point out that these treaty promises have in fact been consistently broken by the Federal Government's imposition of restrictive measures, such as the Migratory Birds

Convention Act. The result was dire hardship for many individuals who depended on this type of game for food. There have also been many federal-provincial legal squabbles because of provincial regulations governing the use of natural resources, in conflict with "treaty rights", which the federal government is supposed to protect. This kind of undermining of food supply, along with concommitent attempts to impose agriculture and a drastically different diet, probably contributed to widespread malnutrition, as witnessed to in this 1947 testimony:

> The majority of the Indians we saw, according to our present day medical standards, were sick. They were not sick according to lay opinion, but when we examined them carefully from the medical standpoint, they had so many obvious evidences of malnutrition that if you or I were in the same condition, we would demand hospitalization at once . . . In trying to find out what was at the bottom of this situation we studied the food which the Indians had . . . We found, according to our present day standards, the Indians received a diet which could not possibly result in good health (Cumming and Mickenberg:207).

Malnutrition resulting from government regulation is a striking example of the historical structuring of the relationship between native people and the white Government, resulting in direct and manifest health problems. This illustrates how important it is to maintain an awareness of the relationship between health and the totality of the socio-economic and cultural context produced by power relationships.

The Medicine Chest

In the negotiations of Treaty #6 (1876-99), the Chiefs, acutely aware of the problems of health in the recent past, requested through their interpreter Peter Erasmus, that the treaty stipulate that there

would be "a free supply of medicines". The Lieutenant Governor replied verbally: "A medicine chest will be kept at the house of each Indian Agent, in case of sickness amongst you." The actual text of the formal written treaty stated it thus: "That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians, at the discretion of such Agent" (Indian Assoc. of Alberta: 1970:33).

In the written text of Treaty #8 (1899) there is no mention of the medicine chest, but in the official report of the Commissioners the following is recorded:

> They requested that medicines be furnished. At Vermillion, Chipewyan and Smith's Landing, an earnest appeal was made for the services of a medical man . . . We promised that supplies of medicines would be put in the charge of persons selected by the Government at different points, and would be distributed free to those of the Indians who might require them. We explained that it would be practically impossible for the Government to arrange for regular medical attendance upon Indians so widely scattered over such an extensive territory. We assured them, however, that the Government would always be ready to avail itself of any opportunity of affording medical service just as it provided that the physician attached to the Commission should give free attendance to all Indians whom he might find in need of treatment as he passed through the country (Cumming and Mickenberg: 1972:33).

In this century, two legal cases occurred, which are documented in Cumming and Mickenberg's book, in which the Treaty #6 "medical chest" provision was at issue:

1) Dreaver vs. the King (1935): Chief Dreaver, who was a witness at the signing of Treaty #6, claimed that "the understanding was that all medicines were to be supplied free to the Indians and that such medicines had been supplied gratuitously from 1876-1919" (Cumming and Mickenberg:129).

The judge ruled, referring to the medicine chest provision of Treaty #6, "I take it to mean that all medicine, drugs, or medical supplies which might be required by the Indians . . . were to be supplied to them free of charge" (cited in Cumming and Mickenberg:129).

2) Regina vs. Johnston (1966): The defendant was charged with failure to pay a hospital tax required by the Saskatchewan Hospitalization Act. The lower court upheld Johnston's position that the Federal Government was obligated to pay the medical expenses of Treaty Indians. However, the Saskatchewan Court of Appeal gave a more limited, literal interpretation of the medicine chest provision, and excluded hospital care.

Medical care of registered Indians had been transferred from the Department of Indian Affairs to the Department of National Health and Welfare in 1945, when Medicare was only a dream. (HWC's Medical Services Branch up to this day is responsible for native health care.)

Social change in Canada as a whole has brought us to the position of providing universal hospitalization coverage, although some provinces charge insurance premiums, allow hospital user fees, and permit extra billing by doctors. In 1971, an Alberta cabinet Order-in-Council exempted treaty Indians from paying medicare premiums. The Medical Services Branch, in fact, provides complete health services for all treaty Indians residing on reserves. The payment of extra billing to physicians remains at issue.

Reflection

Originally, the treaties were negotiated in order to secure land

for an agricultural hinterland for the Upper Canadian metropole as part of Canada's "National Policy". In the present day, the land covered by these treaties are receiving the impact of "internal national expansion". According to Frank, this type of "satellite development" is neither self-generating nor self-perpetuating (Frank:8). This expansion in Canada is into those satellite regions with the heaviest concentrations of native populations (the Mid-North and Far North). The current target of the metropolitan groups is not the development of agricultural land but the exploitation of natural resources: oil, minerals, lumber, and hydro power.

Peter Usher, in his study of Eskimo trappers on Banks Island, described in the following passage how the metropolitan areas dominate the hinterland:

> The impact of metropolitan values and interests on the hinterland has become increasingly pervasive, undermining the very basis of smaller and more traditional societies or communities. While the resulting homogenization of society as a whole is not totally without benefit to the hinterland, the price paid is seen by many as exorbitant. The degree of control and direction over this process by the hinterland is very limited, and the choice as to whether the process should occur at all is simply nonexistent. The commonly accepted proposition that this process is inevitable and beyond individual or collective control, has never been proven. At present it is more in the nature of a self-fulfilling prophecy (Sanders:1974:1).

Nowhere is the ambivalence of the Government's dealings more graphically displayed than in the blatant contradiction in the structure of the federal Department of Indian Affairs and Northern Development. Indian Affairs includes the Government's responsibility

to protect the rights of Indians on traditional lands; Northern Development facilitates the exploitation of natural resources from these lands for metropolitan purposes. Two areas of policy-making which must often lead in opposite directions are wedded together; there is little doubt which direction prevails in cases of conflict. Attempts are made at the policy level to separate resource extraction, with its benefits to southerners, from the life of permanent northern residents, who pay the social and environmental costs, as witness the drilling for oil in the Beaufort Sea, or the James Bay and Manitoba Hydro-electric projects.

Native Health

Early Observations of Native Health

Notes from the earliest contact periods between Indians and whites reflect the strikingly good health that was observed among the Indians. Thus it was noted in 1670:

> They were not subject to disease, and knew nothing of fevers If any accident happened to them . . . they did not need a physician. They had knowledge of herbs, of which they made use, and straight away grew well. They were not subject to the gout, gravel, fevers, or rheumatism. The general remedy was to make themselves sweat, something which they did every month and even oftener (Jaenen: 1976:104, citing Denys: 1688).

Similarly, Peter Erasmus, metis interpreter for the chiefs at the signing of Treaty #6, reported of the Stoney tribe of Alberta:

> They developed the use of medicines to a degree unsurpassed by any of the other tribes. It was largely through their knowledge of medicine plants that the Crees looked to them as friends and never bothered them when they went after Buffalo in that area bordering the North Saskatchewan River. Toothaches and common ailments were hardly heard of before

> the advent of white men's food. I never had a toothache in my life, have been wet to the skin hundreds of times, yet never had a cold till I settled down to what is now known as civilized living. Indians had purgatives, mild or severe as the occasion demanded. Bladder troubles were unknown among the Indians . . .(Erasmus: 1976:74;149)

Contrary to popular misconceptions, Indian health seems to have been superior to that of Europeans at the time of first contact. A way of life in harmony with the environment appears to have promoted a holistic state of health and well-being. The imposition of "civilization" seems to have had a destructive impact on their way of life and the health that was a result of that way.

Underdevelopment and Nutrition

Historically, malnutrition was largely an induced phenomenon amongst native people, as a result of the policy of wiping out the buffalo and restricting traditional land-use, thus undermining the normal diet of the Indians. The natives were then forced into dependence on agricultural foods (pork, potatoes) which they were not used to. They were rendered dependent on an alternation between charitable hand-outs, and seasonal cheap labour in agriculture, and were increasingly cut off from previously accessible food sources.

More recently, the link between health and food resources and dietary patterns has been documented by Dr. Otto Schaefer (1974), medical research officer in the Arctic. His work covers the 1950's through the 70's, and focuses particularly on the Inuit. Much of his research deals with the deleterious impact of bottle-feeding babies.

Shaefer describes a native carving of the period, "A mother bent down by the load of two children only a year apart in age on her back, where there is a place for only one. She obviously blamed bottle

feeding for it, as the artist indicates by placing a milk bottle in the hands of one of the infants." In the 50's Schaefer documented the shortening of the intervals between pregnancies in direct relationship to the proximity of trading posts and availability and use of formula powder. The natural birth control effect of lactation was eliminated, cutting in half the interval between births. The rate of change is indicated by the fact that only 2.7% of adults over age 17 had been bottle fed, compared to 49.5% of children under that age. The percentage of bottle-fed children increased markedly from hunting camps through villages to more urbanized settlements. With the advent of compulsory schooling in the mid-50's, the nomadic life-style of Eskimo families was radically altered, as they moved into government housing settlements close to the schools, to be near their children.

Schaefer documents a series of ways in which improper nutrition education given by health personnel undermined normal, cheap, nutritious dietary practices amongst the Eskimo:

1. "Pre-chewed" infant food was discouraged in favour of less nutritious cereals on the advice of visiting pediatric consultants, largely dependent on the data supplied by cereal companies, and illustrating the short shrift given nutrition education in most medical schools.

2. Nurses studying in university for the "expanded" role in the North were told by a leading Canadian nutritionist that a properly prepared formula was equivalent, if not superior, to mother's milk (ignoring the difficulties of proper preparation, the rich nutrition of mother's milk, its superior sterility, vitamin content, immunizing agents,

cheapness and availability).

3. Obstetritians were known to order birth control medication for native women three days post partum, thus suppressing lactation.

4. At Yellowknife Hospital, where most Central Arctic Eskimo women go to be delivered, orders were given to start feeding the babies with glucose in water and infant formula before breast milk flow could be established, again forcing mothers to abandon breast feeding.

Research in Third World countries and in Saskatchewan indicates that the companies producing infant formula pursue an aggressive promotional campaign to develop markets for their product. Free promotional materials and "starter" kits, demonstrated by hired nurses, have been permitted inside the hospitals themselves, creating the impression that bottle feeding is medically recommended. Advertising creates the illusion that the formula will produce happy, healthy babies. Unfortunately, the truth is often the opposite; breast-fed babies are generally better nourished. Formula, lacking maternal antibodies contained in mother's milk, is often prepared with unsterile water and excessively diluted because of cost. The resultant combination of infection and malnutrition is reflected in infant mortality rates and frequent hospital admissions.

Canadian perinatal and infant mortality rates have shown a decline since 1973, but those provinces which have the largest native populations, and the most isolated communities, reflect higher figures. In Manitoba, the native neonatal, postneonatal, and infant death rates were higher than the same rates for the total provincial population in 1979. The postneonatal rates show the most outstanding

disparity between the rate of 3.4 per thousand for the provincial population, and 9.4 per thousand for Indian reserves.

In a profile of native populations: perinatal deaths are higher; infant death rates are nearly twice that of the provincial population; incidence of congenital anomalies are higher; there is a higher rate of low birth weight, and high birth weight; childbearing begins in very early years and extends into older years, with a higher rate of adolescent pregnancies and higher average number of births per mother; there is a higher rate of hospitalization for Indian infants than for infants generally, and higher number of patient days in hospital for complications during pregnancy for native mothers. Causes of infant deaths include gastrointestinal infections, respiratory infections, and congenital anomalies. Other factors include less access to medical facilities, limited antenatal care, poverty, poor housing, isolation, lack of sewage disposal and potable water (Manitoba Community Task Force on Maternal and Child Health: 1981:18).

The above report suggests program developments with the native population to provide modern knowledge and traditional approaches to family planning, nutrition, childbearing, breastfeeding, childrearing, and parenting, utilizing local resource people (Manitoba Community Task Force on Maternal and Child Health: Discussion paper on High Risk Population: 1981:37).

There have been changes in the Manitoba Region of Medical Services Branch. There has been one nutritionist working out of the Winnipeg office, which does not address the above metropole/hinterland type of situation but does reflect a greater awareness of nutrition as a

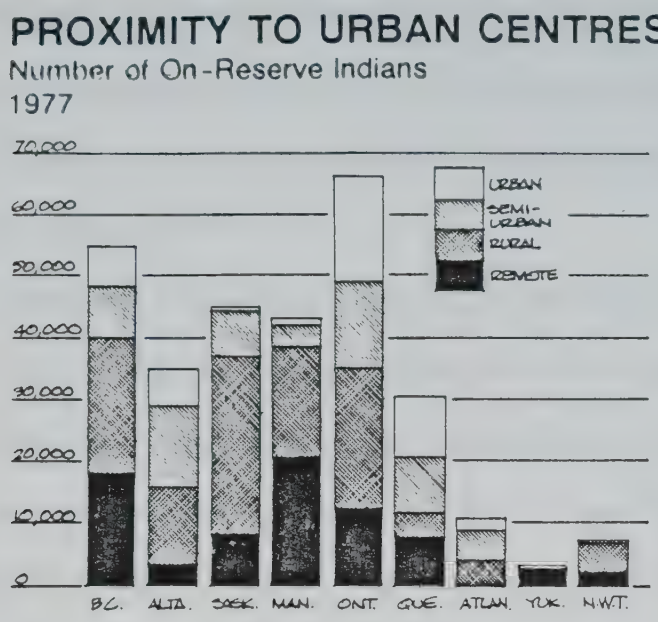
dimension of health. There is a concerted promotion of breast-feeding, with publication of pamphlets, surveys being carried out, and the benefits of breast-feeding strongly emphasized in pre-natal contacts. On The Pas Reserve there has been an observable trend towards breast-feeding, even among teenage mothers. The first baby is an important one to motivate the "Mum" to breast-feed. A positive first experience will help ensure that succeeding children will also be breast-fed. However these changes will have very limited benefits if the economics of food production and distribution remain the same, geared to the interests of the metropole or dominant society.

Underdevelopment and Environment

Health is affected by various environmental factors, such as isolation, housing, and physical amenities.

As can be seen from the accompanying graph, Manitoba has in actual numbers the most Indians living in remote areas of any province. The on-reserve Indian population remains a predominantly rural, remote, and northern population. Isolation may have the benefit of preserving more of the traditions related to to hunting, trapping and fishing, as well as providing a buffer against rapid cultural change. Traditional healing practices and medicinal remedies survive more commonly in the remoter communities, but are less accessible for recognition and integration by mainstream health professionals.

FIGURE (from Indian Conditions: A Survey: 1980:12)



Source:
"Registered Indian Population by Region, by Residence, by Georgraphic Classification, as of December 31, 1977"

DIAND

Seventy-one percent of all bands, representing about 65% of the total registered Indian population, are situated in either rural or remote locations. This compares to less than 25% of the national population living in rural areas.

Distance affects health care. Specialized personnel and treatment facilities are located in major metropolitan centres, requiring considerable travel for consultation or treatment, sometimes for extended periods of time. This adds the stress of loneliness and isolation, and the separation of family members.

Isolation makes for a more hazardous existence. Risk factors in Indian and non-Indian rural or remote areas are comparable. They are: greater use of firearms for hunting; substandard housing and heating systems; inadequate fire-fighting equipment; poor access to medical assistance. The overall rate of violent deaths for Indians is three times the national average. For Indians one to fourteen years of age, burns, drowning, and vehicle accidents account for 69% of accidental deaths. For Indians fifteen years and older, the leading causes are vehicle accidents, drowning, and firearms. Accidents, violence, and

poisonings account for over one-third of all deaths among Indians compared with 9% in Canada as a whole (Indian Affairs: 1980:17). Suicides account for 35% of accidental deaths in the 15-24 age group, contributing to a rate almost three times the national suicide rate (Ibid.:19).

Whereas the Schaefer article stresses the link between poor nutrition and health problems, a 1969 study commissioned by the Medical Services Branch entitled "Study of Health Services for Canadian Indians" emphasized environmental variables as the major link to poor health status: "Indian housing and sanitation are particularly inadequate". Overcrowding is such that the native ratio of persons per room is three times the national average. A significant proportion of native homes are lacking in various equipment considered basic elsewhere.

> The quality and availability of serviced housing has improved, but Indian housing lasts about 15 years compared to 35 years for non-Indians. There is a need today for about 11,000 houses to relieve crowding and replace unsatisfactory housing (Indian Affairs: 1980:30).

On The Pas Reserve, all the houses are electrified, and half have water and sewage service. Some communities in northern Manitoba have a diesel generator for electrical service, and no water and sewage service. The best adjective for most Reserve housing is "inappropriate". As energy becomes more expensive, and society becomes more energy conscious, it is apparent that the design of northern housing is inefficient for heating. Because of inadequate

funding per house, they are built of the cheapest materials, unable to withstand the wear and tear of large extended families. Overcrowding, lack of heat, and unsanitary water and sewage, can be major contributors to poor health in the community as a whole.

Although large sums have been allocated for providing such amenities, much of the money does not get spent on native people. Joe Dion, past president of the Indian Association of Alberta, stated that only 12 cents out of every dollar makes it out of the federal bureaucracy to the community level. Following the deaths of several infants on the Assumption Reserve, Alberta, it came to light that money allocated for running water to homes only supplied the homes of government employees, although it was paid for with the Band's own funds. (Speech: H. Cardinal, University of Alberta, March, 1979)

The Medical Services Branch also notes that diseases frequently recur in Indians after treatment, as a result of returning to the same unhealthy environment. They cite a number of other factors, such as cultural differences and economic dependency.

Underdevelopment and Cultural Conflict

Because of the cultural and language gap between those providing health services and the recipients, Indians tend to regard modern medicine as something foreign. Basic differences in concept and value of such things as time, nature, material accumulation, can lead to resistance of modern medical treatment and reliance on aboriginal medical practices.

A lack of understanding leads to an underutilization of health services for treatment of symptoms which, when left untreated, lead to

more acute illness; and conversely, to overutilization of the same services for minor problems more appropriate for self treatment. Poor educational acheivement contributes to a basic lack of understanding of biological concepts of good health, and inability to respond to public health education delivered in English; schooling itself is an alienating experience, and does not connect with the natives' own perceptions and culture.

There have been massive changes over the past twenty years on reserves such as The Pas. Twenty years ago, reserve children were told never to speak to a white person who came to the door. When reserve residents went to the movies in town, they had to sit on one side of the theatre; if someone forgot, a loud reminder was given. The reserve had its own school. All this is now changed but the legacy of socialization as victims of racism is still present, as well as forms of racism more subtle. "I have mixed feelings about living on a reserve. It feels like a prison. And when I leave the reserve, it's like another country with another set of rules" (Indian speaker: The Pas Reserve: 1983).

Recently, the author was told that the basic problem with the young people on the reserve is that they lack confidence in themselves. Various adults have reported feeling uncomfortable at ethnically mixed meetings; white people are perceived as domineering in discussion, leaving no room for contributions from every member of the group, as is systematically done in native meetings. It seems from these representative opinions that there is an awareness of "two worlds". Native people often feel uncomfortable and lack confidence

when in the other "world". No doubt the reverse is true for whites, who feel alien in the ghettoes created by the institution of Reserves.

This lack of confidence as a result of cross-cultural stress undermines attempts to take positive action to solve the community's problems, and contributes to depression and its symptoms.

Underdevelopment and Economic Dependency

On The Pas Reserve the use of social assistance and welfare has increased from slightly more than one third of the population to more than 60% in the last 10 years (Welfare Worker, The Pas Band, 1984).

Factors contributing to unemployment among native people include: competition for jobs with the children of the baby boom of the late fifties; the decrease in price and supply of furs; change in life-style to one of increasing dependency on government services; the recent recession. The lack of jobs in these communities is reflected in such health-related phenomena as mental depression, alcoholism, and violence to others and self.

The paternalistic approach of government agencies has contributed to lack of initiative, and the traditional economy and sources of employment (hunting, fishing, trapping), while undermined, have not been effectively replaced with other opportunities. This dependency has been increased, since the lack of work has entailed a reliance on welfare payments; 40% of native people received welfare cheques in 1968, and 55% in 1974 compared to 6% for the general population (Indian Affairs: 1980:28). Motivation to improve living conditions or health status is undermined by families living on welfare without their livelihood at stake. Relocation programs to move Indians to job

training and work opportunities have been largely unsuccessful; one reason may be that the native cultural and spiritual values placed on the land and on being close to kinfolk has not been understood in the planning process.

Regulations, directives and policy are formulated elsewhere, not in the communities themselves. To lobby government or make any input into the decision-making process requires the expense in time and money of travelling to a head office or metropolitan centre. In health matters, the experts and specialists are usually located in these centres, requiring travel out of the community for expert consultation, or procedures that in urban communities would be near at hand. Progressive bands like The Pas, which have set up many of their own regulations and policies, are in increasing conflict with government departments which claim jurisdiction in the same areas. Funding is a key to implementing programmes and policies, and is controlled by outside agencies. The stress of constantly struggling for self-determination on a daily basis results in high levels of stress-related illness in Band staff and leadership.

> For the individual to delegate his responsibility for health care to doctors or to governments is a violation of the fundamental natural laws by which preventive medicine and wellness can and should prevail. The solution will come in seeking out and recognizing the social, economic, occupational, environmental, nutritional and spiritual causes of disease, and in becoming directly involved in the eradication of these causes. The solution will come in educating people as to how to stay healthy.(Obamsawin: 1983:196).

This quotation indicates the relevance of Community Development as an approach to solving health problems on a community scale. Health

problems are shown to have their roots in community problems and the historical relations between northern native communities and the dominant society. A community-based approach will be shown to be the best method to mobilize the resources of the community to deal with its problems, specifically to meet health needs, and to educate nursing personnel.

In Northern Manitoba, the Northern Flood Agreement and the Forebay Project, both resulting from native groups trying to achieve some compensation for massive flooding by Manitoba Hydro, attest to the continuing problems that native communities face from the designs and needs of the resource-hungry urban centres of southern Canada.

Ginsberg's study of 1980, to establish the relationship of health and development in northern Manitoba, describes the problems thus:

> despite the level of expenditure, a small percentage of native northerners is employed full time, their incomes are lower, and they have fewer educational opportunities with which to prepare themselves for the job market. Their standard of living as measured by maternal and child health and nutrition levels and by amenities like sewage and water systems and quality of housing is lower than it is for most other Manitobans (1980:2).

Strengths of the Community: Community Praxis

It is not the intention of the author to paint only a bleak, problem-ridden picture of northern native communities. To do so would indicate a despair in the face of many challenges and changes. From this nurse's perspective, immersed through work in one particular community, The Pas Reserve, many positive observations come to mind.

The people of the north over many generations have developed a way of life that makes the most of their environment. The quality of sharing pervades their social life. They are close to nature, to the

spiritual world, and to one another. The grief of broken families is balanced by an openness to adopting one another's children, expressed in the modern context through their own Awasis Agency.

There is a great desire to innovate and a large capacity for making changes for the better. There is a dilemma in relying on government funding for projects, but this problem is well articulated. There is a resiliency and high tolerance for frustration in negotiations. There is a high level of incentive for independence. The traditions around living off the land, of maintaining kinship ties and the language remain valued.

The enjoyment of work is valued and the sociable characteristics of humour, teasing, mutual respect, and a no-fuss approach to getting the work done makes for a satisfying work experience amongst staff.

The potential for action is high, as demonstrated by the articulation of opinions, problems, and solutions by the people. This is evident to me as a participant-observer in the role of community nurse. For example, elders have theories on the prevalence of diabetes in the population. Staff have made observations and have theories on the increase of single parenting, and the implications for child care. Strategies to feedback these is part of the process to stimulate transforming change. To move beyond the immediacy of the health problems that confront us on a day-to-day basis and to shift from an individualistic approach towards a group approach of reflection on these problems is an on-going challenge.

The main point to be made is that the community has the capacity to make the transforming change and engage in its own praxis. Some

examples of this kind of praxis in local communities follows.

The Labrador Inuit Association reported to the People's Food Commission (a non-government public participation project):

> Fishing is the sole source of paid employment for most people. Fishing season lasts only three months, and during that time fishermen must earn all they can (selling their entire catch) to qualify for unemployment insurance. The alternative is welfare.
>
> In the summer, the fish plant operates commercially but when that is finished, people should be able to keep fresh wild meat in the plant's freezer rather than having meat shipped in rotten and not worth the prices we have to pay.
>
> We would like to see the store buying seal meat and fish from people in Hopedale and reselling it to the public. It is not fair that everything should go out of the community. It is not helping us. No one can get cod, trout, etc., in the store.
>
> There is never enough salt cod and frozen fish kept in the store. Everything is shipped out and there is nothing left for the people to buy (People's Food Commission Newsletter: 1979).

This sample of quotations from ordinary Inuit of Labrador demonstrates the ability of local people to reflect on their own situation and diagnose their problems when given the opportunity. These people also proposed various practical solutions to the problems they identified.

In February 1983, The Pas Band included the following statement in a presentation to the Governor-General's Conference on Industry:

> When people have jobs on the Reserve or off the Reserve there is more cash available. Jobs provide more cash in the pocket: therefore, those with jobs have more choice-making to do in the supermarket. From a Public Health viewpoint, this means education needs to be done to promote nutritious food choices . . .

> The work skills that many family units have in obtaining food from the bush or water, are skills that should not be lost. Not only do hunting and fishing feed the soul of the people's heritage, but they also feed families when economic times are tough. Therefore, hunting and fishing rights must continue to be respected and maintained. As well as easing a tight budget, being able to gather food from the bush or water provides a sense of security and identity to the Reserve community.

These quotations indicate an awareness on the part of native people of a relationship of dependency and control vis a vis the dominant society. The economics of the dominant society impinge on the way native people make their living, in ways that may not be immediately apparent to policy-makers. Governments and health workers need to be made sensitive to the ramifications of their regulations, and responsive to local needs and rights.

Reflection

This section has examined native health problems as they have developed from early times. There are indications that native health declined as a result of contact with the Euro-Canadian culture, not merely from such medical factors as exposure to new diseases, but because the socio-economic base for good community health was undermined. The growing dominance of the foreign culture forced the native culture into the position of an underdeveloped hinterland. This led to the loss of many natural and human resources for health, including traditional remedies and nutrition.

All the above reports indicate the importance of considering the total context, including the cultural and socio-economic factors that must be evaluated before priorities are established in health delivery

programs. There is no point treating the symptom without addressing the underlying cause, which is often socio-economic. In particular, relationships are established between land, culture and nutrition, and questions are raised as to the impact of health personnel and their training. Health professionals who have not been educated to be sensitive to the community context of health problems have sometimes contributed to the erosion of traditional resources and cultural strengths, as in the case of breast-feeding.

The next section will describe some of the institution-based constraints of the social context which have placed barriers in front of the native peoples' attempts to make transforming changes in their society. These limitations, imposed from outside the community, are bound up in the larger vertical structures of the dominant society, but must be struggled with to effect change at the community level.

Health Structures, Programs, and Services

Personnel Problems

"The needs of various sub-groups of the population and geographic area differ, and medical facilities require varying types of organizational patterns under different circumstances "
(Lewis, Fein, Mechanic: 1976:10).

The announcement (January, 1979) by Monique Begin, Minister of National Health and Welfare, that registered Indians not on welfare would have to pay Medicare premiums to the provinces, has helped to raise health care issues to critical consciousness amongst Indian people. In Edmonton, 2,000 native people demonstrated against this move. The thrust of their argument was that their premiums have been

paid ages ago, by the loss of their land and way of life, and that the treaties promised the provision of health care (the "medicine chest").

The withdrawal of the right to free medical care was perceived by the native people as an attempt to assimilate and extinguish them by removing one of their distinctive rights. The federal government probably saw it as the transfer of an annoying responsibility to the provincial governments, who are normally responsible for health care, and probably viewed it more in the light of federal-provincial relations than of native rights. However that may be, the move was arbitrary and ostensibly non-negotiable (although some back-pedalling soon followed the strong reaction). It carried to the native people a non-verbal message, that the white people were again forgetful of an historic promise, and would be forgetful in other areas too.

The health services provided to native people have not been beyond reproach in themselves, as the following excerpts will show, in respect to both strengths and inadequacies. According to the Royal Commission on Health Services (1965) the main problems with regard to native communities are: small populations scattered over a large and inaccessible teritory; harsh climate; lack of communications and transportation; lagging social and community services. These problems are closely related to the slow economic development of native areas, and are reflected in: high mortality rates, especially of infants; respiratory diseases (pneumonia, TB); accidents. Long term, a need was seen for: education of the local people to assume the work roles now assumed by imported workers from the south; community development to assist local people in benefitting from economic development and

improvement in their own services. (Twenty years later the nursing jobs are filled by imported workers.)

> The shortage of highly skilled health personnel in the Medical Services Branch is seriously limiting the effectiveness of the Indian health services. Medical school and professional association agreements represent a positive approach to resolving personnel problems (Medical Services Branch: 1969).

As an example of this type of agreement in Manitoba, the Northern Medical Unit of the University of Manitoba contracted with Medical Services to provide physicians, on either a resident or fly-in basis to a number of northern communities.

> "Patch-up" and emergency care rather than comprehensive medical services are often provided in areas with inadequate numbers of health personnel. Little public health education is conducted by nurses because of the lack of time, and in some instances, lack of interest in teaching public health.
>
> Continuity of health care is lacking as a result of the shortage of personnel and the high turnover.
>
> The effectiveness . . . is often impaired because the new personnel do not receive sufficient orientation before being placed in the field. Consequently, new personnel often lack an understanding of the Indian culture and the conditions and problems to expect . . .
> Medical school agreements which involve clear and continuing responsibility for providing Indian health services are beneficial to Indians, the medical schools, and the Medical Services Branch, especially in isolated areas (Medical Services Branch: 1969).
>
> Based on the expenditure made by the Medical Services Branch, per capita expenditures on Indian health services appear to be lower than the national average. Federal expenditures for Indian health services have increased steadily . . . It should be noted that the estimates for the total Canadian population do not include as many categories as do the estimates for the Indian population, so that relative to the total Canadian population the estimates for the Indian population are overstated (Ibid. 27-28).

Ten years later, the continuing problem of filling vacancies in the North Zone, Manitoba Region, Medical Services, illustrates the contradiction of establishing a service yet not providing the means of producing adequately prepared nursing and physician staff.

> Another significant factor during 1979 has been the acute shortage of nurses in the field and the absence of a Regional Nursing Officer for almost a year (the position was filled for a short period during the year) and a Zone Nursing Officer in North Zone. The nursing shortage in the field became so acute that the Acting Regional Nursing Officer, Ms. Rita Dozois, the Regional Personnel Adviser and Ms. Maria Holubowsky from Branch Headquarters went on a recruiting tour through eastern Canada which led to some alleviation of the situation. However, it was not possible to obtain sufficient experienced nurses and there continued to be vacant positions. Since the nurse is the lynch-pin of practically all Medical Services' programs in the Manitoba Region, this was a very serious situation, which still continues, which affects a priority, namely: preventive public health programs. A feature contributory to nursing turnover and dissatisfaction was financial restraint and the restriction of training programs (Health and Welfare Canada: Manitoba Region 1979 Annual Report).

Recommendations for improving health services delivery need to be analyzed in terms of the following questions: Are there conditions which may impede development? Are the native people themselves involved, or are there significant channels for real involvement, not of a "token" or "advisory" nature, but transferring power and responsibility? One organizational solution established in 1982 by the Medical Services Branch in Manitoba, is to create a new department called "Community-based Health Services". At present, this Department is staffed by categories of workers who are native, i.e., CHRs, Alcohol Counsellors, and a native nurse is administrative manager.

It remains to be seen whether the Department of Community-based Services will enable the evolution of representative structuring

throughout the province or Region. More significant perhaps is the formation, under the direction of the Northern Manitoba chiefs' organization (MKO), of an all-native, six-member Health Council, which is funded by Medical Services, but takes its own initiatives.

Between 1978-80 consultations were held at the national level amongst Indian representatives. These consultations entitled "National Commission Inquiry on Indian Health" resulted in a number of policy papers. The major thrust was for the establishment of structures to promote the transfer of control of Indian health services to Indian people. The formation of Health Councils or Boards at the provincial, district, and Band levels was proposed as the means for providing representation from the grassroots and accountability for funding and programming. The MKO Health Council is one such group potentially engaged in the praxis of making health structures their own. The danger with the goal of transferring control of Indian health services to Indian people is that of neo-colonialism -- changing management's face from white to brown, but permitting no other fundamental changes, e.g. the bureaucratic structures, the regulations as constructed in Ottawa, the polity, all remaining the same. This would epitomize the worst of transmitted change.

Local Health Structures

In 1975, the Health Centre for The Pas Band relocated, from a site in the Town of The Pas "across the river", to a site on the Reserve, first in the old Band Offices, and in 1977 into the new Otineka Mall shopping centre. At the same time, the Band gained more administrative control over the budget, including the hiring of

Community Health Representatives (CHRs), the Referral Clerk, and the Nurse, the administration of a local transportation budget and a small operating budget. This reflects a policy of "transfer of control" to local Bands in administration of certain areas of health service.

The Pas Band is the only case in Northern Manitoba where this transfer includes the Nurse position. This results in much closer cooperation between the Nurse and CHRs in health services, and with the Band Council in administrative matters. The Nurse is an employee of the Band rather than of Medical Services, and assists the Band in negotiations with the federal government. This structure also facilitates closer liaison with other Band departments -- Public Works, Social Services, Education, Alcohol Counsellors.

The budget for these health services is contained in a Contribution Agreement with Health and Welfare Canada, Medical Services Branch, and depends on an annual negotiation process with the North Zone, Manitoba Region, located in Thompson. Until the early 1970s, The Pas was the Zone office, but as Thompson became the major centre in the North, the Zone office was re-located there.

At about this time, the Zone office in The Pas was picketed. Stories differ as to the reasons; one informant described it as a protest against the administrator, another recalls that it was because there was a proposal from Health and Welfare to cancel the coverage of medical transportation for native people. Transportation coverage was retained as one of the services provided treaty people, but the Zone office was moved to Thompson. A more militant attitude can be dated from this period, as The Pas Band struggled to gain

greater control over government-funded services.

The Contribution Agreements provide a continuing focal point for this struggle, as the Band attempts to obtain more administrative discretion in spending this budget, while Medical Services, under the influence of the recession and bureaucratic motives, tries to exert further control over the spending choices.

In 1982-83, for example, the Band's health budget was underspent by about $6,000 in the local transportation section; the Band wanted to use this surplus to acquire audio-visual equipment needed for health education programs. The Zone administration declared "no capital equipment" could be acquired. Under earlier agreements, some flexibility was allowed in transferring monies from one category to another; thus, an area of control had been withdrawn from the Band. As a result of this type of dispute, the Band resisted signing an agreement for 1983-84 unless its discretionary powers were widened.

Mention should also be made regarding the health delivery problems in the region. There are seven bands in the Swampy Cree Tribal Council area. This organization deals with issues of common concern to treaty people living in the region. Adjacent to each of the seven reserves are settlements of non-treaty people, with kinship ties to their treaty neighbours. The Federal and Provincial Governments have an understanding that only one level of government will administer health services in each community, depending on whether the majority were status or non-status. Thus two bands (The Pas and Pukatawagen) relate to Medical Services Branch of Health and Welfare Canada, while the other five bands receive health services through the Provincial

Health Department.

The Provincial Health Department appears to give lower priority to serving their five communities than does the federal Medical Services, as evidenced by failure to recruit resident nurses or provide regular visiting doctors in several Swampy Cree communities.

The Pas Reserve

History

The Pas Reserve shares much of its history with the Town of The Pas. Both communities are located on opposite sides of the Saskatchewan River, fed by two tributaries, the Carrot River and the Opasquia River. Not far from where the Saskatchewan finally empties into the Lake Winnipeg system, The Pas was an important stop on the water routes between the Prairies and Hudson Bay. The name is a corruption of a Cree word "Opasquiak" meaning "High ground". As solid land in the midst of marshy lowlands, it functioned as a seasonal meeting-place for the Swampy Cree, for whom the mixture of marsh, bush, and water provided a plentiful source of fish and game.

A permanent settlement was already established according to documents from the time of the explorer Henry Kelsey (c. 1680-90), who travelled through the area. It continued as a stopping place and small post on the Hudson's Bay Company route between Fort York and Fort Edmonton. The Carrot River Valley's rich delta soil encouraged agricultural experiments. The first grain in western Canada was grown here in 1754 by the explorer Capt. Louis de la Corne St. Luc. A Montreal farmer, Joseph Constant, settled here to farm in 1800, marrying into the Swampy Cree. Anglican missionary teacher Henry Budd

(described below) encouraged the growth of agriculture amongst the Cree from the 1840s, although the Company is said to have discouraged it in favour of trapping (The Pas Historical Society: 1983).

Early contact with European culture came through the Church. A native boy, baptized "Henry Budd", was trained at the Red River settlement by the Church Missionary Society (CMS) and sent as teacher and catechist to The Pas in 1840. He established a church and school, and exercised his organizational ability in building a strong church community amongst the Swampy Cree; his agricultural leadership saved them from the starvation that was sweeping the Prairies. Working under the supervision of various British clergy, Budd became the first Anglican priest of native ancestry in Western Canada. Budd was quite Victorian, and effectively eliminated much of the practice of Indian religion; he was able to report "we have now no heathen Indians at all at Devon" (The Pas Historical Society: 1983:94). The majority of The Pas Band still belong to the Anglican Church, which is a prominent part of community life. During the 1840s, Roman Catholic missionaries also visited the area, probably ministering mainly to Metis families, but it was not until 1887 that Father Ovide Charlebois established a more permanent presence.

Political events in the South introduced further change in the 1870s. The Red River Settlement (Winnipeg) had been established in 1812. Following Confederation in 1867, the national policy of western expansion and settlement provoked the Riel Rebellion in 1870. To stabilize the situation, the "postage-stamp" Province of Manitoba was formed in the south, and a series of "numbered treaties" were

initiated with Indian bands. Development was moving north as well as west. 1874 saw the first steam-ship successfully ply the route from Grand Rapids past The Pas to Carlton House, and there was already talk of a railroad to Hudson Bay to gain shorter access to Europe. Treaty Five, covering most of what is now northern Manitoba, was first signed at Norway House , September 20, 1875. This was followed by "adhesions" (signatures by other bands); The Pas Band signed September 7, 1876.

The Canadian Northern Railway Company eventually reached The Pas with their Hudson Bay Railway in 1908. This created an influx of white settlers, lumbermen, trappers and prospectors. In anticipation of this, a change was made to Treaty Five in 1906: the southern side of the river was surrendered to become the Town site, and the Band, numbering about 500, were moved across to the northern side of the river. Band members believe the move was to give the settlers the more arable land, since the Reserve has more gravel. The Reserve lands are in nineteen pieces, including traditional fishing sites on two lakes further north, and hunting areas along the Carrot River into Saskatchewan. The Town site is encircled by various sections of Reserve land, and the Band is researching claims inside the Town limits dating back to the move across the river.

The Town of The Pas was incorporated in 1912, the same year the region was joined to the Province of Manitoba. Steady growth took place following World War I. The Pas became a centre for rail transportation as several branch lines converged from mining towns further north, and the Hudson Bay Line reached Churchill in 1929. The

lumber industry grew, and farmers escaping the Saskatchewan dust-bowl in the 1930s revitalized agriculture. A highway from the south arrived in the 1920's. Hydro-electric developments further north altered water levels, as did the "Saskeram" system of dikes in the Carrot River Valley. The establishment of Manitoba Forestry Resources Inc. ("Manfor") brought rapid expansion in the 1960s. It was only 15-20 years ago that some Reserve residents acquired cars and residents recall that up until then, their housing consisted of shacks; then the Government instituted a house-building program.

Natural and Human Resources

The Reserve lands contain a diversity of natural resources: sand and gravel, wildlife, timber, farm land, recreational and building sites. The climate is "continental sub-arctic" with a short growing season (balanced by long hours of day-light) in the summer.

Improvement in the employment situation has been marked. In 1979, about half the potential labour force had work. However, many of these jobs are in intermittent or lower paying jobs which means the average income is less than the average for the region. About one third of the Band members received social assistance, and 5% received only old age pension (The Pas Band Land Use Study:1979). Since the recession of the 80's, however, 60% of Band members now receive social assistance.

The major sources of employment for Band members are: the provincial Crown corporation, Manfor lumber mill (Manitoba Forestry Resources, Ltd.); Band administration, and retail outlets in the Band-owned Otineka shopping mall (IGA -- 51% Band-owned -- native

handicraft store, parka manufacuring and retail outlet). Sixty percent of these jobs are on the Reserve.

Otineka Mall is independently incorporated and depends on leases to finance itself. The economic base for the mall's development was a combination of government grants (federal-provincial) and the Band's own Nakow Corporation, a gravel and sand operation. The Band's gravel was a major supplier for highway development, and provided jobs and profit; this is no longer the case, since the Highways Department now obtain their gravel from a CNR pit.

In 1979 the Band membership was 1340, 90% of these living on-reserve. A conservative estimate in 1979 projected that the on-reserve population would reach 1800 by 1995. Reasons for such an increase appear to be related to more housing starts in recent years combined with return migration of young families. Twenty percent of Reserve residents have completed high school or post-secondary education in contrast to almost 50% of the Town population.

Recent developments include the opening of a large shopping mall on the Reserve (1976). Twenty-six retail outlets lease the ground floor. The second floor has leased office space to the provincial government, and includes office space for the Band Administration, Swampy Cree Tribal Council, and the Otineka Health Centre. The Swampy Cree Tribal Council, representing seven bands in north-western Manitoba, has offices up-stairs in the mall, and employs about 12 people. (The Pas is the geographical hub of the Swampy Cree area.) In the basement level are a nursery and kindergarten with 90 pupils and 4 native teachers, and an alternative high school program

with three teachers for native students experiencing difficulty with the Junior and Senior High School in Town. An Adult Basic Education learning centre is located in the mall, funded by CEIC (Employment Canada) and includes about fifteen adults upgrading their high school education.

The Pas Band is at present trying to appropriate control over schooling at all levels. Other Swampy Cree reserves, which are more isolated from white communities, have their own elementary and junior high schools. The Pas Band children are mostly enrolled in schools located in the Town of The Pas. In the autumn of 1983, the Band Council informed the Kelsey School Division Board that they would be withdrawing all Band children from the schools in September 1984. This desire was fed by several factors gradually over the past twenty years, since integration of the previous schools: high drop-out rate, low number of grade twelve graduates, loss of Cree language in the younger generation, few native teachers. The Band could see new schools being built in the more remote communities, with a better percentage of native teachers, more use of Cree, better attendance, more graduates, as well as local autonomy. However, Indian Affairs has a long waiting-list of schools that need building, and recently the Band was told that funding would not be available until the end of the decade. Band leadership still seems committed to removing their children from Kelsey School Division, and in 1984, one hundred children were placed in a renovated building, becoming a Reserve school.

The Band has also sought more input into program planning at

the local Keewatin Community College. Conversations with the latest Director have explored the possibility of offering more professional and university-level programs through the College. However, the Manitoba Department of Education has given no mandate to the College for such programming, and the College's own efforts do not seem to be focused in this direction. Although the Band Council and the Swampy Cree Tribal Council have expressed official support for the idea of their own nursing education program, this does not appear to be a high priority for them either. The health staff interpret this as reflecting a low priority to female roles such as nursing. On the other hand, the Band was concerned to arrange to have their own visiting doctor, who holds clinics in the Health Centre twice weekly. The Band would also like to have its own small hospital and ambulance, although these services are just across the river. It is easier to visualize "concrete" needs like buildings, than the training programs to staff them.

Culture and Heritage

"My culture isn't smoking a pipe; I don't understand those ceremonies; it's not my culture. My culture is being able to go out and trap in the Spring, hunt in the Fall, and enjoy the comforts that society provides. A lot of people make the mistake of confusing heritage and culture. Customs learned from the past are heritage; but culture is who you are in the present. The most important part of culture is your language." (Indian speaker, The Pas Band, 1982)

These statements are examples of the self-aware expression of leaders of The Pas Band as they seek self-determination within a

larger social context. This kind of reflection undergirds the strategies and actions the Band takes on its own behalf. To the researcher, such statements provide data that assists in understanding the community's self-concept.

Peter Puxley argues, with Freire, for a definition of culture which is based on cultural action by a people seeking the political restructuring of social relationships. It involves, therefore, a "forging of a new identity on the part of those who would free themselves from the given" (1979:1). In the above statements, "the given" is equated with heritage from the past, a heritage which may or may not be appropriated in the present; the "new identity" is a living combination of things old and new, a way of living in the present.

"I couldn't sleep last night. Yesterday my son was outside working, and he heard a voice whisper his name." This quotation illustrates the survival of native spirituality, a world-view that is strikingly different from the technological world-view of the dominant society. Rather than fearing for her son's sanity because he is hearing voices, this mother takes the voice seriously as an omen that requires interpretation. Although this difference might be expressed in a list of folk-beliefs, it is better described as an over-all attitude or attention towards a spiritual dimension to existence.

Implications for Nursing Education

The last few sections have continued the investigation of health care delivery to northern native peoples, and have introduced the local particulars of The Pas Reserve. The relationship of reserve communities to the dominant institutions which are supposed to serve

their needs sharpens the case for describing them as hinterland. Native communities, and in particular The Pas Reserve, do not have the power to determine how to solve their own problems. They may have lost much of their former culture, but still retain a distinctive approach to life, and find themselves in a uniquely powerless position to determine their own lives.

This underdevelopment process has undermined the general health of native communities, and contributed to inadequate health delivery, including a low supply of health workers, especially those equipped to understand the native context, or those from a native background.

Health workers in native communities must be trained to see health in its total community context. Health education, and in particular nursing education, must reflect the total context in the content of curriculum and in teaching methods. Teacher and students should be involved in an interaction of praxis with the roots of health problems in all their social complexity. This implies learning institutions that are much more closely related to the community, and in particular to native communities, than has been the case.

Health that is developed in its total community context will also contribute to the socio-economic health of the community. In the next chapter, attention will turn to the broad subject of health, health care, and health education from a community-based perspective.

CHAPTER III: COMMUNITY DEVELOPMENT THEMES IN HEALTH DELIVERY AND NURSING EDUCATION

Towards a Definition of Health

Here, the thesis is concerned with a definition of health that takes seriously the relationship of health to its social context: health as an integral part of the larger totality of the local community and the wider society. This definition, however, is based in a large body of health-related literature, and grows naturally out of the health disciplines themselves.

Wu (1973) discusses the concepts of wellness and illness, and raises the question whether there is a universal standard or criterion of wellness. She outlines three possible relationships between wellness and illness from her search of the literature: "Wellness as the polar opposite of illness, wellness on a graduated scale with illness, wellness as a separate dimension from illness" (Wu: 1973:76). In the first two cases, health and disease concepts are directly related to one another; in the third, wellness is entirely distinct from illness. Wu argues that the individual's experience and the resultant behaviour will provide the basis for assessing either an illness or a wellness state. "Health-wellness is manifested by a feeling of well-being, a capacity to perform to the best of one's ability; an ability to adjust to and adapt creatively to varying situations, to perceive correctly free from need distortions, complemented with a wholesome outlook on life" (Wu: 1973:86).

Wu expands on the definition of health adopted by the World Health Organization (W.H.O.): "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or

infirmity." This definition reflects the trend in health-care thinking away from the "medical model", in which a cause and effect relationship is limited to a view of a disease-causing organism such as bacteria, manifesting itself in symptoms leading to disability or death in the human organism. The trend is toward a larger, more ecological view that there are underlying multiple reasons for ill health. This leads toward a focus on disease prevention and health promotion.

The subjective nature of definitions of health is revealed by the Cree concept "menowawin" which translates as "I'm feeling good" and reflects a holistic view and sense of "well-being" mentioned by Wu. Given the assumption that this Community Development approach respects the felt needs and search for development goals and strategies inherent amongst the members of a community, the Cree word and concept for health should be the basis of any strategy relating to health in their community. The concept appears to be compatible with that "sense of well-being". Those activities which maintain and promote that feeling may well be expressed in form unique to the community members, their culture, and local social organization.

In Canada, this trend in conceptualization was expressed in Lalonde's 1974 report A New Perspective on the Health of Canadians. The "Health Field" concept elaborated in this document includes four categories which affect health:(11-13)

1. environment: those factors external to the human body over which the individual has little or no control;
2. lifestyle: those choices and behaviours of individuals which affect their health and which they can control;

3. biology: those physical and elemental factors which develop within the human body;

4. health care organization: the people, resources and systems which provide health care.

This analytical framework assists in enlarging our view of the totality of health to include socio-political and physical environments and the resultant barriers and resources for the maintenance of health.

The implications for our health-care system of the view that health and illness are not on the same continuum, but are different variables, is enormous. The Canadian nursing educator, Allen states:

> Our priorities should be directed toward the development of healthful living styles, of healthy families, and of healthy communities. It is time to identify and to plan for the resources that are required. As a social phenomenon, health tends to be an attribute of a group, or of a family or community. The individual is, to a large extent, healthy as a reflection of some larger unit. Health is related to potentials, strengths, and aspirations and not to inadequacies, lack and limitations . . . this implies a broader scope for the function of nursing in our society—a role in which nursing is the primary health resource for families and the community (Allen: 1979:57).

The nurse's role as a primary health-care worker, is to assist individuals and families to cope with specific types of life situations. Illness is viewed as only one feature of the health of the community, and is integrated within family and community life (Ibid.: 58). Nursing education which embodies the above view will provide practice opportunities in homes, health centres, schools, as well as hospitals.

In this chapter the fields of health and nursing education will

be briefly surveyed from an historical-structural perspective, in order to identify points of contradiction and possibilities for creative change. A broad-brush picture of the history of nursing education in Canada will be presented in order to describe some of the contradictions and conflicts in the nursing role which have emerged, particularly in its social relations with physicians, hospitals, educational institutions, and the community. In the course of this discussion, some influential trends in the larger society are noted. Lessons will be drawn from documented experiences of health workers in the Third World, as they attempt to provide primary care, and from examples of community-based models of services and education in our own society. These innovations will present possible directions of change for our own society, especially in the context of native society. From the nursing discipline itself, criteria will be derived to describe effective nursing education programs.

Historical Development in Canadian Nursing Education

The goal of this section is to describe the developing sub-culture of nursing education within an historical-structural frame of reference, the cultural conflict between nursing education and hospital settings, and between nursing practice and its community setting, and to identify a possible trend in nursing education.

Early Development

Until the last two decades there have been two major strands in the preparation of diploma registered nurses in Canada: the religious, and the para-military. Both have, in fact, much in common.

The first developments were in French religious orders who established hospitals in New France to care for the sick in the

Quebec City and Montreal area in the seventeenth century (Canadian Nurses Association: 1968:27). Religious orders, usually women's orders, administer hospitals which they have established to this day. The training of nurses in the orders was not unique, although the sub-culture within which it took place was characterized both by personal values implicit in Christianity, and monastic discipline typical of celibate communities.

A significant departure was initiated by Florence Nightingale in the mid-nineteenth century, who blended the feminine and religious (in her case, Protestant) stream of nursing with the male-oriented para-military stream. Following the Crimean War, Nightingale sought to up-grade the quality -- both character and standards -- of British nursing personnel (Nightingale: 1969). Prior to Nightingale, males provided most nursing care to the injured on the military front-line. In England, females who had originally been functioning as "wet-nurses" or servants were drawn into the military nursing situation. After the Crimean War, Nightingale (herself of the upper class) was able to inspire some women of the upper and middle classes to become involved in the nursing school movement, as benefactors, as educators, and eventually as trainees, motivated by an ideal of religious and patriotic service to others.

Nursing schools as such became established around the turn of the century, and Canadian schools were heavily influenced by the English example. Personnel trained in England, and Canadians trained in Nightingale-inspired schools of nursing in the USA, formed the faculty and administration of these early Canadian schools (Canadian Nurses Association: 1968: 31). The training methodology was that of

apprenticeship, learning on the job; the control over the total lives of the students could be described as monastic and military; the motivation to serve was not unlike the vocation of religious orders. This type of total control over the lives of nursing students continued into the early sixties. Students learned "on the job", which included gruelling hours of menial duty round the clock; it was compulsory to live "in residence", reminiscent of the cloistering of nuns in their convent (although without the explicit religious commitment, and more rebellion); even marriage was forbidden during training. Students were on the bottom rank in an authoritarian hierarchy, carrying out "orders" initiated by a (usually male) doctor, relayed by a senior nurse. The exception was in university-based programs, the first of which was established at the University of British Columbia in 1919 (Ibid.: 33).

In summary, the early nursing schools were: female in membership; hierarchical/authoritarian in structure; idealistically dedicated in motivation.

Cultural Change and Contradiction in Nursing Education

If culture is defined as "the integrated system of learned behaviour patterns that are characteristic of the members of a society," (Hoebel: 1976:18) then a sub-culture can be defined as a sub-set of the above. A sub-culture reflects many features of the total system, but also shares a unique pattern of characteristics, derived from an identifiable sub-group within the society, that can be differentiated from the culture as a whole.

It can be argued that a sub-culture, although exhibiting a unique pattern of behaviour, reflects the overall assumptions and cultural

postulates of the larger society. It could further be argued that in a dynamic situation in which cultural change is taking place in the society as a whole, such change will also be taking place in its subcultures, but at an accelerated or retarded rate, so that different sets of norms and values will be found to overlap and conflict. This has been true in the sub-culture of nursing in Canada, and especially nursing education, since the Second World War.

Before the Second World War, nursing exhibited to a marked degree sexual stereotyping in its role function, reflecting the larger culture's maintenance of role discrimination on the basis of sex (Ashley: 1976:91). Nurses ran their hospitals (homes) but the doctors (male) dominated the treatment plan of the patient (child). Authority was hierarchical, and flowed "down" as treatment plans in the linguistic and organizational mode characteristic of the relationship between male and female in the larger culture. The sort of communication characteristic of males and females in the larger society was transferred to the doctor-nurse relationship, and fed back in the oft-fulfilled fantasy of doctor-marries-nurse! Social control, in the form of quasi-military discipline, assured the acculturation of nurse-apprentices into learning this nurse-role in the particular institution where she trained.

The 1939-45 War catalyzed a blurring of many of these stereotyped, sex-linked roles, as women replaced men in factories while the men left Canada to fight. A shift in values was facilitated in the direction of more egalitarian norms implicit in the general assumptions of North American democracy (Fritz: 1968:202). After this War, there was an explosion of educational opportunities,

initially geared to returning veterans, and this provided a further pressure for change.

Nursing educators and nursing students of the 60's had become increasingly uncomfortable with hospital-based nursing schools. These schools were a cultural anomoly as educational institutions; their postulates were increasingly incongruous with, or in contradiction to, society at large:

1) they exercised a heavy control over the lives of students, in a society developing increasingly egalitarian models; the strict rules of compulsory residence life were in constant conflict with the personal lives of students;

2) they practiced an authoritarian style of decision-making whiich did not sit well with the aspirations of students, who wanted more direct input into decisions which affected their own lives and future;

3) their reliance on an out-moded "apprenticeship" pedagogy was out of step with the more sophisticated clinical approach to learning, based on selected learning experiences rather than on sheer quantity of practice;

4) their reliance on nursing students as cheap labour within the hospital was experienced as exploitation by the students, and was seen by faculty as detracting from a more intentionally educational use of limited learning time;

5) they were almost entirely female, in a society breaking down sex-role stereotypes.

To comment on this last feature, one might note that a continuing feature of nursing culture generally is its femaleness. Legislative authority can move nursing education from hospitals into colleges, but

it cannot move males into nursing careers. The interface between the traditional female sub-culture of nursing and the larger Women's Movement within the culture at large is complex. Precisely because it has remained a female-dominated profession, nursing has benefitted from the the impetus of the Women's Movement, and continues to provide a professional career option for women.

The New Situation

Over the past two decades, radical changes have taken place in nursing education, primarily due to two factors: the "knowledge explosion" and Americanization. A general explosion of knowledge in the medical field stimulated the attempt to develop the scientific basis for the art of nursing, and a growing need to specialize in one field of nursing practice (Brown: 1968:173). This trend in turn, drawing on the social and managerial sciences, produced a growing self-consciousness of nursing as a profession in its own right. Heavier influence was being felt from the U.S.A., where a more liberal approach to nursing education was being developed.

In nursing practice, behavioural and educational sciences have produced profound changes, shifting from a functional, efficiency-oriented, assembly-line approach, to a case and team approach, more patient-centred and problem-solving. This more dynamic approach engages a team composed of a variety of experts (doctors, medical specialists, occupational- and physio-therapists, nurses, dieticians, social workers, psychiatrists, chaplains) in identifying problems and applying their particular expertise in a clinical, coordinated, problem-solving style.

During the second World War, the need for specialties in nursing

was recognized. For example, Canadian military nurses were sent to the USA to learn flight nursing (Nicholson: 1975:213). The need for broader and deeper preparation in the arts and sciences, and a more professional level of competence, led to the establishment of university schools of nursing leading to the Bachelor of Nursing (BN), Bachelor of Science in Nursing (BSN) degree, or equivalent. This trend became evident in Canada after World War II. It was necessary for nurses seeking advanced education to go to the U.S.A, for masters or doctoral studies, as in many other fields (The Symons Report: 1974:144). This facilitated a process of cultural diffusion, a major mechanism of change, whereby individuals initiate new behaviours on the basis of changed values learned in another culture.

Since the late 1960's, a process of indigenizing some of this American-inspired change has been going on, reflecting the larger Canadian ambivalence towards the dominant American culture. Until the late 60's, Canadian nursing graduates wrote examinations prepared in the U.S.A. (by the National League of Nursing). However, the development of stronger, more organized and slightly more militant nursing associations at the provincial level resulted in a Canadian examination prepared and distributed by the Canadian Nurses' Association in the 1970's.

The leaders within the field of nursing education found themselves increasingly at variance with the domination of educational needs by the service needs of the hospitals which administered the schools. Influenced by educational thinkers such as Rogers (1969:304) they were changing pedagogy and curriculum to reflect a more self-directed, problem-solving approach to learning. Growing autonomy of nursing

schools moved from a situation in which the hospital used the school as a source of cheap semi-skilled labour, to a situation in which the school used the hospital, and to some extent other community-based settings, as a source of clinical experience. Finally, this changed relationship was institutionalized by moving the majority of nursing schools out of the hospitals and into community college settings, as departments within an educational institution.

Nursing schools have been subject to the same changes as the larger culture. It should be remembered that these changes are never unambiguous, that there are always "countervailing trends", and that the old contradictions are likely to re-emerge in new forms.

This transition is not without tension. The structural and organizational changes may have taken place officially, led by administrators whose approach is more informed by "scientific principles". However, conflict will often emerge in an inter-generational context, for example, between an older nurse trained in the earlier model, operating on the "efficiency-routine model" of assembly-line care, and a younger nurse trying to adapt herself on a more individual basis to the patient's own rhythms and needs. Frequently, the "service" needs of the hospital put pressure on staff to adopt the more routine approach, especially where there are staff shortages. The graduate under the new system will often find herself ill-equipped to cope with the heavy work load, in contrast to the problem-centred, selective work-load of her educational experience.

There are still two basic philosophies of nursing in conflict, each now institutionalized in the college and the hospital,

respectively. It is in the area of clinical educational experience that the two philosophies come into open conflict. Students often have to "practise" their new skills in real situations that are operating on the earlier model, officially or unofficially. An Alberta task-force reported thus: "A barrier exists between nursing education and nursing service. The new graduate is not prepared for the 'real' world. Nursing service does not provide opportunities for new graduates to function as they have been taught." (Alberta Task Force:1975:88).

Profession or Paraprofession

A different kind of problem has been documented in American literature. A trend has emerged which has considerably polarized nurses. Professional elites have proposed two separate nursing careers: the two-year RN course, leading to a support-role as a "technical" nurse, and the four-year BSN course at university level leading to a leadership role as a "professional" nurse (Koch: 1977:20). In Canada, by contrast, the practice in most provinces has been an articulation of RN and BSN programs, so that the RN can be a step towards the BSN, with transfer credits towards university programs. The potential exists for a similar polarization between RNs and the "vocational" level of nursing assistant (LPN or RNA), whose continued existence is questioned:

> That vocational and technical-vocational levels of nursing education be phased into the technical level as soon as it is feasible to do so, that there be provision for mobility, and that the vocational category be maintained in service as long as there are vocational nurses actively practicing" (Manitoba Association of Registered Nurses: 1976:163).

An issue currently under discussion in nursing associations throughout Canada is whether "entry to practice" as a nurse should require a Baccalaureate in Nursing as a prerequisite, rather than the RN diploma. Medical Services Branch, Manitoba Region, was in support of community-based "BN" education because experience on reserves indicated to them that the BN level of nurse was needed to manage tthe variety of calls on judgment-making and to implement public health education. Most provincial associations have approved this change in principle, and some have set a target date of the year 2000. This does not seem to have a direct bearing on whether to implement a more community-based approach in diploma and degree courses at present. However, it does have a bearing on what type of programs are developed in the future, especially in disadvantaged areas such as the North.

Most proposals for northern nursing programs fit into the two-year diploma model (with additional "up-grading" components at the front end). While this represents a short-term gain, in the long run it will produce under-qualified graduates. In the next decade, there will be a need to up-grade these graduates to the degree level, and to design future programs to the degree level rather than the diploma level. In diploma level programs, there is limited time available for community-based experiences and cross-cultural learning (although the community-based approach is just as feasible at this level). However, degree level courses have more time available for this type of content. Furthermore, the goal of such courses is a more independent, problem-solving professional, such as is required in the isolated conditions of remote communities. A four-year program may seem an unrealistic investment of time for the educationally disadvantaged,

unless it is designed as a "career ladder" with more than one exit level. However, the four-year program does create opportunities for a richer curriculum than the two-year program.

In northern Manitoba at present, LPNs continue to be graduated in The Pas, and RNs may soon be graduating in Thompson. Although economic pressures encourage the hiring of less qualified staff, the trend towards degree level nursing suggests there will be extensive need for up-grading for LPNs and RNs in the years ahead. This need creates another opportunity for community-based education.

On reserves, similar arguments apply to the division of labour between CHRs and more qualified personnel. The CHR continues to fill a vital gap in the delivery of health care to the community, and represents the beginnings of a more community-based approach. However, the training received and the role assigned is very limited compared to the full range of practitioner skills demanded by remote location, or commended by a more community-based approach to the full range of health services. A community-based approach to the training of RNs and BNs represents an further extension of the model piloted by CHRs. The Manitoba Indian Nurses' Association supports this view. In conversation with some native RN graduates, members of this organization, the belief was expressed that their educational preparation in the urban setting of the hospital did not fit them with the confidence and competence to work in a more remote northern community. These needs lend support to the thesis under discussion.

Contradiction in the Health Care Delivery System

The present situation in the health care delivery system will be sketched within the perspective of the historical-structural paradigm,

in order to set the context for considering nursing education for native communities. Problems in the health care field provide an example of contradictory structures at work around issues of class and sex. These must be addressed in developing a nursing program.

To avoid the hinterland/metropole process developing in northern nursing education, any program would have to educate nurses within the reality of the community setting, taking note of the internal politics of the community, the politics of government, the history of relations with government (particularly with health institutions), racial prejudice in the larger society, epidemiology of health problems and their inter-relationship to other community and societal problems. Amongst these social factors, understanding and coping with the intrusion of sexism into the changing sex roles in families, the politics of the community, and the administration of health care institutions, is a necessary curriculum component.

Our society places a high value on health care; 7.1% of the G.N.P. was expended on health care in 1971 (Lalonde: 1974:27); the education of highly skilled, specialized personnel is expensive, and large budgets are consumed by capital projects such as hospitals, and by expensive technological gadgetry (Allentuck: 1978:8).

> The traditional or generally accepted view of the health field is that the art or science of medicine has been the fount from which all improvements in health have flowed, and popular belief equates the level of health with the quality of medicine . . . Individual health care, in particular, has had a dominant position, and expenditures have generally been directed at improving its quality and accessibility . . . The consequence of the traditional view is that most direct expenditures on health are physician-centred . . . (Lalonde: 1974:11).

Sophisticated technology and techniques are forcing health care professionals to take a fresh look at health care, free from the narrowly curative medical point of view. Questions concerning the nature of death and the quality of life, prevention and lifestyle, industrial safety and environmental hazard, nutrition and poverty, and the inequitable distribution of resources, are some of the issues being wrestled with.

Internationally, our health system operates similarly to other economic relationships, by funnelling the resources of other, poorer (hinterland) countries into our own. Nearly one half of our doctors are "imports", a large percentage of whom have received expensive medical training in Third World countries of origin. Within Canada itself, regional economic disparities operate to ensure that the metropolitan centres have the highest proportion of best-qualified personnel, while many rural hinterland areas receive minimal primary medical care. Although nursing care is largely available it is intermittent as it undergoes large turn-overs of personnel. These rural areas receive a high proportion of immigrant doctors, who are forced to settle there if they wish to practice medicine (an example of "cooperation" between Medical Associations and the Department of Immigration) (Allentuck: 1978:23). In The Pas, all the physicians are immigrants, predominantly from Britain. Health and Welfare Canada has a tradition of recruiting in Britain to fill nursing positions on Indian reserves. This is an example of the metropolis-hinterland model typical throughout industrial society, in which centralization of political and economic power drains the resources of the Canadian hinterland into the urban centres, and of international hinterlands

into the Canadian hinterland. A migration study of physicians and nurses demonstrates this model.

> A country like Jamaica which is much poorer than Canada and considerably richer than some of the islands surrounding it is both a donor of physicians to Canada and a recipient of physicians from the islands. At the higher level of the income scale, an example is the U.K. which is a donor of physicians to Canada and the U.S.A., both richer than the U.K., and a recipient of physicians from much poorer countries such as India, Nigeria, and Pakistan...It has been shown it is the action taken at the recipient end that effectively controls the size of the flows (WHO:1979:417).

The study makes the following observations concerning the educational preparation of physicians and nurses:

> Much of the education being provided in developing countries is not relevant to the health needs of the majority of the people in the country concerned but is modelled on the education being provided in developed countries. The overproduction of highly skilled manpower is reflected in a lack of middle level manpower in general and of nursing personnel, in particular . . . Even in developed countries it is now recognized that a feasible system of primary health care cannot in the long run be based predominantly on the services of personnel who are not only costly to produce and utilize, but also have received a training geared to sophisticated secondary and tertiary rather than primary levels of health care. . . Health personnel can serve a country's needs for health care only to the extent that the education and training they receive focus on technology (content, methods, equipment, facilities, etc.) oriented to such needs (WHO: 1979:426).

An enlarged capacity to train health personnel will result if learning opportunities are problem- and learner-oriented; include self-learning opportunities; and are provided through a system of continuing education linked to job requirements and (to the extent possible) at the job site (WHO: 1979:426).

The data and conclusions of the above study suggest the major

importance of education that is appropriate to the health needs of the majority of the population in the area served; considers manpower needs; encourages learning to take place in the typical site of the job need.

Conflict, and the potential for change, emerge when the hinterland organizes and resists. Attempts in Northern Manitoba in the past decade have been made to obtain educational opportunities for northerners. There has been some success in teacher-education in remote native communities through the BUNTEP program, which will be discussed later on. More recently, RN, social worker, child-care worker, and business administration programs have been initiated in a northern urban centre - Thompson.

Implications may be drawn for health education in the North. The majority of learning experiences for health workers of all types should take place in northern communities. The community nurse is the most fitting role to develop to meet the needs of northern native communities. It provides an avenue for native people to access the scientific knowledge base in nursing and to take over their own health services and to reconstruct them to serve their own local needs.

The goal of our system is generally stated as universal health care, but the reality, encouraged by a capital-intensive approach to budgeting, can be called disease-care. The procedures of disease-care are centred in the doctor as answer-man, from whom all initiative for medical care, hospital care, laboratory tests, and drugs, must flow. The narrow focus on the doctor's curative role draws funds and attention away from the major preventive measures which are the responsibilities of others. The relative value of

doctors in improving overall standards of health has been studied by Dr. Thomas McKeon of Birmingham using historical analysis. He concludes that, "in order of importance, the major contributions to improvement in health in England and Wales were from limitations in family size (a behavioural and values change), increase in food supplies (an economic change), and a healthier physical environment (environmental influence), and specific preventive and therapeutic measures" (Lalonde:13).

> Present cost-sharing arrangements between the provincial and federal governments tend to encourage the use of physicians and acute treatment hospitals, even for services which could be adequately provided through less costly means (Lalonde:28).

Hospital construction and acute care beds are in excess of the needs of the population, but there is a shortage of facilities for convalescent and long-term treatment, or alternative arrangements such as group homes, for emotional rehabilitation, the handicapped, day-care patients, or "live-in" facilities for ambulatory, out-of-town patients who need daily treatments but not twenty-four hour hospital care. Community level preventive care, health education and home-care are all limited in their development because funding is dominated by annual escalations to keep expensive acute care plants running. This leads to misuse of these costly facilities for less-than-acute care (Lalonde: 1974:28). The lack of round-the-clock availability of doctors in offices and clinics leads to over-use and misuse of emergency departments in hospitals.

A large portion of health care budgets pays the fees of a comparatively few health workers -- the doctors. The power structure

is similar to those of business and industrial concerns, with a small elite at the top (doctors in place of corporate executives) (Allentuck: 1978:16). While often in conflict with government over their own fee scales, they tend to form a common interest with government in keeping down other health care costs such as nurses' salaries, as in the 1977 nurses' strike in Alberta. As in society at large, power is concentrated at the top, and the mystification attached to the role of Doctor helps keep subservient groups ignorant of their own health needs, and reinforces a sense of powerlessness. In this situation, the nurse is the person in the middle, a kind of medical middle class, whose interests have more in common with other health workers and the general public than with the interests of the doctors.

Recent trends indicate a much higher percentage of females enrolled in medical schools. It is too early to tell what impact this will have on roles and structures in the medical sub-culture. Traditional sex-role stereotypes are reflected in the relationship between medical and nursing personnel (Shapiro: 1978:104-108). This is in contradiction to a reverse trend in society at large, and to the growing "professionalization" of nurses as their roles expand to fill areas vacated or never occupied by doctors (e.g., outposts, schools, pre-natal classes, family planning clinics, etc.);"orders", however, still predominate. Doctors are the "gate-keepers" of the system, determining who enters and leaves, and regulating access to other professionals. A large proportion of doctors seem to view themselves as entrepreneurs in a business sense.

The fee-for-service basis of doctor's remuneration reinforces the

profit-making bias in the health care system. A health care system dominated by such an approach is bound to exhibit contradictions. When illness is seen as a source of livelihood rather than as a problem to be solved, the profit motive will encourage the production of disease and dependency, rather than health and self-care.

"Iatrogenesis" is a term gaining currency in literature critical of Western-style health care systems to describe this phenomenon. The concept is ably explained and demonstrated in Ivan Illich's book Medical Nemesis. A brief definition is "physician-created illness"; in a more general sense, clinical iatrogenic disease comprises all clinical conditions for which remedies, physicians, or hospitals and nurses themselves are the "sickening agents" (Illich: 1975:22). According to Dr. Losos, director of Health and Welfare Canada's bureau of disease control (Winnipeg Free Press: June 8:1983:1): "An estimated $645 million is spent each year treating infections patients pick up after entering hospital...Of the estimated four million Canadians who enter hospital each year, 7% or one in every fourteen will pick up some other infection from other patients or hospital staff."

Drug dependency amongst the public is encouraged by the practice of prescribing drugs excessively (Capra: 1983:249). The use of drugs for treatment of anxiety diverts attention from other approaches, such as redirection of lifestyle, humanization of the work-place, stress management. The picture is much the same for non-chemical technology. In the writer's experience a small hospital in Ontario purchased sophisticated equipment for which there was no demand at the patient level and no training at the staff level. It is small wonder that the costs of health care have climbed during the period of lavish

government spending, although costs under private insurance in the USA are reportedly even higher. Too often the response from government is to cut budgets in the personnel area rather than the capital costs area, and not address the underlying causes. The Lalonde report would be an important exception — if it were acted upon.

Essentially in this section the ways economic factors distort health care delivery in our particular type of society have been explored. The answers to many of the above questions depend not simply on research, which can clarify choices, but on values and goals, which can indicate which choices to make. Moreover, it is useful to be aware of the unstated value assumptions which may underlie the contradictions observed in the system.

> Essentially, it is the culture/society system that places value on characteristics inherent in health or illness. It is also the culture/society system that establishes roles related to these values. The progress of health care can be traced through identifying the culture/society system's values about wellness and illness and through describing characteristics of associated roles (Braden: 1976:135).

A significant values conflict is identified (Berger: 1976:2) between the continued desire for services provided by the modern welfare state, and a strong feeling against government, bureaucracy and bigness. Berger suggests that if public policy is to meet the needs of people more successfully, it should encourage and utilize these mediating (small and friendly) structures. All too often, big government finds such small units too frustrating to deal with, and tries to eliminate them.

In the case of native health care delivery, and nursing education, this would mean working through the existing structures for

self-government on the reserves, rather than seeking to eliminate these structures in the assimilationist policies of the Government's 1969 White Paper (Weaver: 1981:178). If the power to carry out policies is decentralized to a more "grass roots" level, responsiveness to real need and responsibility in handling resources is more likely to result. Our current reliance on large-scale health delivery "mega-structures" has as its social product individual dependency, which is productive of illness rather than health. Policy alternatives that reverse this trend are required at this time, both in the dominant society, and in the particular case of native communities.

Community-Based Approaches to Health Care Delivery:

International Level

The Third World provides some models of national policy changes towards a more community-based model of health services as opposed to the ineffective and costly acute-care medical model imported from the West. The need to work simultaneously at the local, national, and possibly international level, is expounded in an article by Dr. Mansalvo of Argentina who is reflecting on the relationship of international aid , national health policy, and community level health promotion strategies. He pictures the integration of these levels and resources for community health betterment in which the "vertical" processes of domination and imposition are replaced with a cooperative, "horizontal" model (Monsalvo: 1982:13).

This attempt to blend the vertical policies and structures with the community's goals through strengthening the horizontal relationship was the focus of an unpublished thesis by Boman (U of A: 1981) in

which Roland Warren's notion (1965) of the need to maintain balance between the vertical and horizontal structures within society is used as an argument for strengthening the ties of members within a community to health delivery structures.

The dependence on outside vertical structures is critiqued by Werner as he reflects on how health programs can either cripple communities or make them whole, based on his experience in Latin America. The self-reliance of the old ways when native communities had their own medicine men, mid-wives, bone setters, psychic healers, and priests, is compared with a transition period when these healers appropriated the "magic" of Western medicine and added antibiotics and other pharmaceuticals to their gamut of herbs and home remedies, creating new categories of healers, the medico praticante (pharmacists) and inyectadoras (women who give injections). With the saving of more lives, population has increased, malnutrition has increased, and "the inequities of land tenure and distribution of wealth have become more oppressive" (Werner: 1976:2). Dependence on the outside for food supplements, medication, education, and direction has resulted in communities becoming "politically voiceless recipients of both aid and exploitation" (Werner: 2). Werner found the most community-supportive projects were often operated on shoe-string budgets by non-government agencies such as Oxfam and the churches, in which the workers "from the outside" lived with the people simply, sharing their knowledge freely with them, and encouraging them to undertake diagnostic, curative as well as health promotion measures, thus obtaining the respect and participation of community residents

(Werner: 2). In contrast, the Canadian system separates the community health thrust from curative health care. Financial support continues to be largely focused on curative measures, and preventive measures remain underdeveloped.

Werner advocates the following community-supportive steps (Werner: 14-16):

1) Decentralization (planning and self-direction from the bottom: advice and coordination from the top);

2) Greater self-sufficiency at the community level;

3) Open-ended planning (flexible, to include field-level people in policy planning sessions);

4) Allowance for variation and growth (support of alternatives and pilot projects);

5) Planned obsolescence of outside in-put (set a cut-off date for external aid);

6) De-professionalization and de-institutionalization (more mutual self-care; promotion of continuing education for health workers in their communities);

7) More curative medicine (primary health workers permitted to diagnose and treat more of the common problems and trained for this);

8) More feed-back between doctors and health workers (e.g., when a patient is referred to a doctor, he should provide a full report back, providing mutual continuing education);

9) Earlier orientation of medical students into community health;

10) Greater appreciation and respect for villagers, their traditions, skills, intelligence, and potential.

11) Selection, as directors and key personnel, of "people who are

human."

His reflections, based on his Latin American experience, provide those in the underdeveloped regions of Canada with suggestions for actions which promote self-reliance at the community level. His points relate more to health development rather than the education of health workers, per se.

He notes that national health policy-makers, as they increase their interventions into the health arena, are increasing controls on the Village Health Workers with the recent breed being taught a very limited range of skills, having to complete an excessive amount of paper-work, and being restricted from curative practice. Some communities have sent students away for professional training with the hope they would return to serve their people; however, it was too soon to evaluate if that was in fact occurring.

On The Pas Reserve, there is an on-going attempt to blend these two aspects of health services (curative and preventive). Highlights of how this is facilitated include:

1) Partial devolution of control to the Band of administration of all health workers, including the nurse, who so far has always come from outside the community. Selection of workers is done by the Band, in contrast to other reserves in northern Manitoba, whose nurses are selected and administered by the Medical Services Branch of the Federal Government.

2) Collective decision-making, utilizing the community's Health and Social Development Committee, and consultation with all health staff, in setting program priorities and in dealing with problems at the community level.

3) Involving a physician in holding regular doctor's clinics and diabetic clinics in the Band's own clinic space. On-going consultation and education between the physician and all other health staff promotes understanding of the social context by the physician and understanding of treatment approaches in chronic and acute care for the health staff. Medical students receive experience at these clinics, with the hope that some Canadian medical graduates will return to the North.

4) Some of the health workers are involved in on-going research of relevance to the community, for example, single parent family patterns; diabetes. Findings are shared with the Health and Social Development Committee in a feedback process.

5) Mental health needs with a community-supportive approach involving medicine men has been sanctioned and encouraged by health professionals, leading to greater utilization of this traditional source of healing expertise.

National Level: Hastings Report

Similar developments can be reported in the Canadian context. One of the most exciting and comprehensive proposals was a report from the Community Health Centre Project. The report was the result of a one year commissioned study, consisting of ninety-two position papers presented to the Conference of Health Ministers (1972) by Dr. John Hastings.

> The central concept of the community health centre is teamwork. The kind of teamwork which is meant is not the kind of teamwork which has been developed in hospital operating theatres, a para-military system to deal with the inert patients, but the milieu therapy approach, developed first in mental hospitals and later in community psychiatry.

> This approach recognizes that all those who have contact with the patient may influence his behaviour and his self-concepts, but that professionals have a special responsibility in making their interventions not only to help the patient but to help others to help him, and to help him to help himself. The focus is not upon the physician as team leader but upon problem-solving processes for the client/patient . . . This approach focuses upon helping the patient to take greater responsibility for his own health and the community to take greater responsibility for its members (Hastings: 1972:366).

A major thrust of the report was to introduce new patterns of care, reallocating resources from hospitals to community health centres, which was seen as more effective in delivering and coordinating health care, as well as more cost-effective. Unfortunately, in Canada there has not been a widespread shift in the direction of Community Health Centres; the idea remains more spoken about than acted upon.

Local Level: Klinic

In Manitoba, an example of this approach is Klinic, in Winnipeg. The Hastings Report defines a Community Health Centre thus:

> a facility or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality. Such care must be provided in an acceptable manner through a team of health professionals and other personnel working in an accessible and well-managed setting. The Community Health Centre must form part of a responsive and accountable health services system. In turn, the health services must be closely and effectively coordinated with the social and related services to help individuals, families, and communities deal with the many-sided problems of living (Ibid.: 362).

In a conversation with a worker at Klinic (April, 1984) it was noted that this innovative centre has been a vanguard in implementing new services, the most recent examples being programs for battered women and victims of sexual assault. This approach facilitates an

inter- disciplinary team effort which treats the physical health problems in their broader social context. The varied needs of individuals are recognized and met in a coordinated, holistic way, instead of passing the individual from one institution to another.

The focus of this thesis is the applicability of the community-based approach to remote northern settings. One should not lose sight of the fact that this approach is equally suited to any type of community, as illustrated by this urban example.

Health Care and Community Development

Feuerstein and Lovel (1983:98) explore the viewpoint that the ideas of Community Development have been "borrowed" throughout the sixties and seventies to achieve certain health objectives. For example, community cooperation evolves into community participation into "partnership", in which inter-sectoral cooperation is seen as necessary for health problems which have their roots in such causes as land inequities, lack of adequate sewage and water systems, etc. The entry point of primary health care is discussed as to the merits of a Community Development approach utilizing the health sector, or vice versa. Even when there is participation in inter-sectoral planning at various levels to promote health development, an inadequate, superficial analysis of the societal context may produce short-sighted solutions to the deeper problems. It is suggested that health programs need to define their roles in the whole development process. Action research methods involving community members in planning and evaluation is suggested to promote consciousness-raising and organized development within the communities.

The health ministers of the member countries of the Pan American

Health Organization (which includes Canada) met in 1972 to consider how health coverage could be extended to meet the rising demand, based on primary care and community participation strategies (PAHO:1974). The focus of need was marginal urban groups and scattered rural populations. Health needs were ranked as follows according to urgency by these marginalized communities: water and food, care at childbirth, treatment of accidents and the most common diseases. An intersectoral approach was defined as necessary, whereby one activity complements an activity of another sector within the community. This was because of the interacting needs of clients, many of which are beyond the control of the health sector. For example, prenatal programs intersect with social services and the child care agency. National health policies and institutional regulations may be required to adapt and promote this approach.

The theme of strengthening self-reliance in Indian communities is developed by Obomsawin, as he critiques the institutionalization of disease and the lack of effort in North America of professions and systems to focus on maintaining health. De-institutionalization and reinstatement of the wholistic nature of human beings, focusing on political self-determination, self-reliance in food production and natural nutrition and education, are the strategic areas he emphasizes (Obomsawin: 1983:196).

The strengths of the community and culture are harnessed and channelled when using a community-based approach.

The Rough Rock Demonstration School in Chinle, Arizona, has spawned a number of native controlled agencies. One of these is the Office of Native Healing Services, Navajo Health Authority. The

Navajo director, Carl Gorman, says, "Many Navajos, even if they get treated in a hospital, will come home to be treated again by a medicine man. Mostly, it's an emotional healing process they seek from their own people." The National Institute for Mental Health (U.S.A.) funds a training program for medicine men at Rough Rock which includes the traditional forms of healing, as well as "Anglo" medical principles. A number of ceremonies fit into a category called the "Blessing Way" and focus on the prevention of illness and misfortune, for example, when a person is going into the hospital or on a trip. The medicine men are also used by the local hospital; they are called in for patients who have a traditional orientation (Fields: 1976:8).

The Participatory Research Project of the International Council for Adult Education was contracted in 1977 by the Band Council of Big Trout Lake in Northwestern Ontario to investigate "all feasible alternative methods of sanitation" (Jackson:1979). This initiative was taken as a result of a government plan to provide a million dollar piped sewage system for government buildings on the reserve. A local committee became involved in monitoring the lake and lagoon waters. Slides were made of the process, so that the community could share its expertise with other northern settlements; the committee was also used for communicating the process through the local radio station, and conducting seminars, public meetings and group interviews, and in contributing to the collation and writing of the final report. In this way, the Band made an informed choice on the basis of the costs and benefits and the environmental and social impacts, and obtained sanitation resources for the whole community, rather than for government buildings only.

The trend throughout the world towards urbanization, which is related to under-employment and under-serviced rural areas is also reflected in the migration flow of native people into Canadian cities in the past decade. The 1980 report of the Manitoba Indian Brotherhood states that the primary reasons for such movement are health needs requiring specialized health services, training and employment opportunities, and housing needs (Manitoba Indian Brotherhood: 1980).

Educational approaches are implicit in a community participation strategy. Learning situations must be fostered to enable people to be not merely the beneficiaries of programs, but the agents of their own development. The community is both the means and the end of the learning process, and therefore teaching programs and objectives must not be copies of imported social and educational models.

The point of view elucidated above has suggestions for the education of health care providers, and implications for a northern nursing education program; for example:

1. The personnel training function must be integrated into the health care services so that dynamic, relevant instruction will be offered.
2. The educational process should take into account the resources available in the traditional community system.
3. Revisions of curricula should give special importance to practice in, and early exposure to, the community, as well as foster the growth of a critical and creative awareness that produces workers who can take on new functions consistent with changing conditions.

Community-based Approaches to Nursing and Nursing Education

Community Health in Nursing Curricula

At an American conference in 1973 on "Redesigning Nursing Education for Public Health" a high-lighted conceptual issue was: Health promotion and disease prevention in light of current knowledge and health trends. The Director of the Federal Division of Nursing (USA), Jessie Scott, outlined the government's high priority concerns reflected in the research it supports: role realignment of the nurse, and programs to prepare nurses for an expanded role in primary care; redistribution of nursing expertise to provide easier access for the consumer to the health care system; analysis of community-specific group phenomena through, for example, the experimental curriculum for community nurse practitioners at the University of Texas; establishing criteria for the establishment of a nurse clinic within a hospital (USA Dept. of Health, Education and Welfare: 1973:3-7).

In summary, the priority at the Federal level appeared to have been to examine and develop an expanded role for nurses in the community. At the same conference Freeman identified the contradictions in public health nursing. More Public Health Nurses (PHNs) exist in ratio to the population, yet only the surface of total need has been scratched. More PHN's are academically prepared, but theory is too meagre for practice and often incongruent with reality. Greater use is made of 'low-cost' personnel, yet costs are rising — that is, population need is not forming the basis for nursing priorities but the medical model is (Ibid: 11-17). Scott suggests that non-conventional learning opportunities might supercede the emphasis on formal education; nursing should make improved inputs into

policy-level decisions and social action thus breaking out of its present isolation; and develop measures of nursing effectiveness without restricting the art to technologically-defined objectives.

Prock addressed the topic regarding the implications of change for nursing practice and education:

> If implementation of the expanded role for the nurse is to come about, then schools of nursing will have to take the responsibility for incorporating appropriate content into the curricula for first level practice wherever that practice may be. Substantial content related to health maintenance, mental health, management of chronic illness, and health education are essential (Ibid.: 91).

The summary of guidelines for nursing education from the conference is oriented to community problems and many of them would make sense if incorporated into an innovative curriculum for native communities.

The Community Nurse Practitioner Program at the University of Texas has incorporated into its curriculum such concepts as community development, self-help, and cooperation in change, as well as traditional methods of assessing communities. The community is viewed as a 'partner' in the change process for health betterment, rather than a 'target' (Flynn 1978:633).

In a nursing program at Indiana University, the concepts and theories of the 'majors' (foundation courses) are "related to different levels of analysis concerning the community, organizations, and the family" (Ibid.: 634). The 'central' thread is primary health care. For practicum, the students are involved in agencies such as: multiservice centres, a neighbourhood health centre, the county and

local councils on aging, and neighbourhood organizations. Information gathered is shared by the students with the various agencies thus promoting inter-agency collaboration.

This program uses Cottrell's concept of community competence as its community assessment model. This concept holds out the possibility of transferring a 'self-care' model of assessment to community care. Eight criteria are identified as the essential conditions for the achievement of community competence. This could be a helpful guide in native communities but would require native analysts to be valid.

This facilitation of the analytical competencies of students is an important process in any nursing education program at any level, using conceptual tools, field experience, and faculty supervision and guidance promoting a reflective student response.

M.V. Ruth and K.B. Partridge elucidate some points relevant to the objective of relating conceptual frameworks to the "community care" aspect of nursing education. "Primary care is not synonymous with public health" (Ruth: 1978:622). Primary care is focused on the individual whereas public health is centrally concerned with populations in their collectivity. Ruth and Partridge are concerned that public health needs are being neglected (e.g., risk assessment, environmental factors) by the enthusiasm for primary care needs and the confusion resulting from some writers' equation of primary care accessibility with community care. They refer to a survey conducted by White in 1975 in which it was found that "nursing course work was minimal in schools of public health, while basic public health sciences (epidemiology, biostatistics, program administration) were frequently missing in schools of nursing" (Ibid.: 624).

The author is unaware of any similar study for Canadian university programs in nursing education; it may be that public health subjects are included at the baccalaureate and master's level programs in most of our university schools. Where they are often omitted is at the R.N. level, which may be appropriate. However, should R.N. diploma programs be established to meet the needs of native students and communities, whether at a community college or university level, it would be essential to include approaches to understanding the care of communities.

Personnel allocations in native communities at present are often no more than from one to three nurses per community, without immediate access to medical personnel; this means the nurse must fulfil a demanding role, similar to the "nurse practitioner". If a nursing education program is to be relevant to the needs of such situations, students will need community-oriented knowledge and skills to function effectively in this sparsely-staffed situation.

The learning process for such a situation should move from the general to the more specific; the progression should be to focus on the community as a whole, on groups with common needs and problems, on families, and on individuals in those groups.

Nursing Education and the Sub-Culture of the Community

The sub-culture of a school of nursing, or of a hospital, is in some tension with the culture around it, because the personnel have been socialized into a specialized set of roles and values. This is true even when the personnel originate in the same culture as the community around them. However, cultural identity between nurse and patient facilitates communication; the author has observed a greater

sense of accountability from nurses towards patients from their own community. On the other hand, if the nurse is from a very different cultural background from that of the patient, communication can be expected to be more difficult. Indeed, "ethnocentric" assumptions come into play, misinterpreting cultural cues and making false conclusions and value judgments. This is exacerbated when the whole community is from a different culture from the nursing staff; stereotypes are readily available, and may even be reinforced by peer pressure amongst the nursing staff. The author is familiar with various incidents in the Outpatients Department of a local hospital, in which native people's symptoms of diabetic shock, angina, etc., were dismissed as drunkenness.

The question must be put, whether the personnel of the hospital, by virtue of their educational experiences being limited to the hospital setting, have been so institutionalized that "real life" in the surrounding community has little relevance to them? Would these personnel have been more discerning, had they received more of their learning experiences in the community? In the northern situation the vast majority of health personnel are from the dominant culture, but the majority of clients are from the Indian culture. This contradiction would be addressed by a nursing education program designed specifically with native students' needs in mind.

Community-Based Learning Experiences

One assumption of community-based nursing education is that students will have access to a significant proportion of planned experiences in nursing practice within the community. Nursing practice consists of applying the nursing process to health-related

problems. Defining the problem, analysing its components, planning solutions, taking action, and evaluating the effectiveness of these actions comprise the nursing process. In the nursing curriculum, learning experiences are planned to give the student the most relevant practice in applying this nursing process to a selection of health-care problems. These problems may be presented in a clinical, institutional setting, such as a hospital, or in more community-based settings such as a family clinic, health centre, or home visit.

The various health-care problems that individuals present may require a nursing approach that focuses on health-maintenance or health-restoration, an acute need that requires quick action or a chronic need that requires long-term adaptation and monitoring. However, all health problems require assessment before implementing a plan of action. Individuals may be grouped according to family, small special-needs groupings, or community-wide groups, depending on the commonalities of health-related problems. In providing a relevant selection of learned experiences, attention must be given to ensuring:

1) practice with all age groups within the community;

2) practice in caring for individuals with common, recurring health problems within the particular community, e.g., chest and ear infections, heart disease, diabetes;

3) practice in providing continuity to the same client over a period of time;

4) practice in applying every step in the nursing process;

5) practice in health education of individuals, small groups, and large groups;

6) practice in pre-natal, post-natal, newborn, pediatric, medical,

surgical, psychiatric and rehabilitative nursing;

7) optimal integration of theory and practice, relating clinical experience and academic instruction;

8) practice in working as part of a professional and para-professional team;

9) practice in collaborating with individuals, families, and community decision-makers to enhance health care;

10) practice in cross-cultural communication skills;

11) practice in developing professional ethics;

12) practice in the range of problems from simple to complex;

13) practice in considering physical, social, emotional, mental and spiritual aspects of clients, thus promoting a holistic and personal approach to nursing.

In summary it can be argued that learning nursing to a greater extent in the community will provide a greater breadth and depth of nursing practice than can be provided in a hospital setting. The hospital setting can provide those acute-care nursing experiences that are restricted to hospitals. Nursing stations provide emergency and acute-care opportunities. But less acute stages of health problems will only be encountered out in the community, particularly in home visits and home care. Experience in preventative and health-promotion approaches are mainly available in the community. There exists a great social distance between specialized institutions like the hospital and the college, and community life, especially in traditional, native communities.

Community Development Approaches to Education: BUNTEP

In Manitoba, the Brandon University Native Teacher Education

Project (BUNTEP) model is an example of a largely community-based project to prepare teachers. It was the subject of an evaluation study carried out in 1980-81 (Canadian Institute for Research:1981). In each community selected, a resident professor with a full-time faculty contract with the University, supervises a group of 8-15 adult students, and carries out teaching, counselling, administrative and coordinating responsibilities. Anticipated benefits were:

1. improved quality of education in the north by increased attendance rates of Indian students, increased retention rates of teachers, increased instructional use of the language of the community, increased attention to Indian culture, life and customs in the curriculum, and increased participation of community members in the educational process;
2. more employment opportunities for northerners in the north;
3. increased opportunities for adult education;
4. increased participation in the operation and policy formulation of BUNTEP, thereby developing leadership skills (Ibid.:3).

The political challenge of this innovative program is described as operating within the ambiguity of two opposing views, the "university-centred" and the "community-centred" conceptions of the program.

> The first school of thought conceives of BUNTEP as essentially an extension of traditional university education and favours a greater role for on-campus programming. The community-centred group stresses the role of BUNTEP in northern development and the development of native peoples. It also views the idea of bringing the university to the community not only in the philosophical sense but also in the sense of making university education relevant to the needs of native communities. In addition BUNTEP is part of current developments in native communities such as local control (Ibid.: 10-11).

"There is general agreement among participants at all levels of the program that improvement in the administration of BUNTEP is needed" (Ibid.: 13). The organizational and administrative weaknesses were identified in policy formation, coordination of the different components of the organization, operational clarity of roles and responsibilities of participants, long term planning, and the system of recognition and rewards.

There are unclear lines of authority and decision-making. The BUNTEP Advisory Committee recommends, but does not decide. The Committee meets infrequently and links Brandon University, the Government of Manitoba, and the University Grants Commission. The cooperating school divisions and the communities are not involved in these decision-making structures. Recommendations 2, 3 and 5 of the evaluation are to establish policy-making authority and accountability in a Management Board. This should extend the Advisory Committee's membership to include representation from field level BUNTEP staff, the communities and school districts which cooperate with the program. Members would work on sub-committees, and a Director would be appointed with a mandate to carry out Board decisions.

Since BUNTEP is the only professional level program available in the more remote Manitoba communities, it provides a model (including avoidable pitfalls) for establishing community-based professional education. It points to the need felt for more participation at the community level in decision-making, or local control.

Evaluation

The Canadian Nurses' Association issued a document in 1978 entitled "Standards for Nursing Evaluation in Canada". In a list of

seven assumptions preceding the Statements on Standards, several are pertinent, especially #4: "Evaluation is inherent in sound planning and implementation of nursing education programs."

The World Health Organization has described the necessity of aligning nursing education better with health care needs and emphasizes the importance of basing curriculum on a firm knowledge of the communities of people to be served, so that the process becomes people-centred rather than institution-centred. "Community nursing includes family health nursing but is also concerned with identifying the community's broad health needs and involving the community in development projects related to health and welfare. It helps communities to identify their own problems, to find solutions, and to take such action as they can before calling on outside assistance."

Hudson's elucidation of praxis as ethically charged social action (1975) emphasizes the doing of intentional actions as a form of evaluation. The community group approaches are methods which help put the statistics of secondary data into its proper context, namely, the lives of people. The willingness of people to discuss, analyze, and make decisions, on their own behalf is probably the most realistic way of validating needs, and moving people towards creating solutions that will work and have staying-power (as contrasted with short-term band-aid solutions). This provides a realistic framework for evaluation, since people do what they can; as they work at defining (a) what is, and (b) what should be, they may be moved to do (c) what can be done, to get from (a) to (b), in what is probably the most efficient way possible. This is a transforming exercise of the self, and hopefully of the world. While it may be ideal to build in formal

evaluation at key moments in the organizing process, this sometimes requires preconditions of staff, time, and established structures that do not apply to the dynamic struggle to bring something new into being out of scarce resources -- as is often the case in Community Development, and certainly is true of some of the case studies discussed later.

Nonetheless, without some basic goals, and some process for measuring the achievement of these, how can the community assess whether its actions are achieving the desired results, or learn from the process? Praxis without reflection degenerates into blind activism. Reflection and evaluation must be inserted in a meaningful way. Results from the Community Health Representative programme demonstrate some evaluation needs for any program designed to train health professionals in a community-based context: (Martens: 1966)

1) need-assessment from the primary normative data approach (using "insiders'" assessment capacity) as well as from secondary sources;

2) cost-benefit analysis, a data-gap in the CHR evaluation;

3) qualifications of candidates for "appropriateness";

4) curriculum design, with community advisors;

5) attitudes of current health professionals to assess "supportive" capacity to such a training programme;

6) selection of good "public relations" actions all along the programme development path.

Criteria for Nursing Education

> The criteria of relevance, relatedness, and accountability, when applied to an educational programme assist in describing the development of that programme and form the basis of the evaluation process (Allen: 1977:13).

These three criteria are suggested by Moyra Allen to evaluate the stages of initial planning, implementation, and outcomes, in the development of nursing education programs. They emerge from the disciplines of nursing and nursing education, and can be used to evaluate both community-based and institution-based schools and curricula. They establish an objective, external yard-stick to assess the claims made in this thesis for the community-based approach.

Relevance is defined as:

> The extent to which the goals, activities and outcomes of the nursing education programme are a response to the needs of a particular community or country.
> Relevancy in teaching is usually related to the teaching staff's understanding of the culture of the community and of the learning modes of the people (1977:10).

Relatedness is defined as:

> The extent to which the parts of the nursing programme, i.e., curriculum, teaching of nursing, practice of nursing and research, and administration, influence each other in developing programme goals and in shaping their achievement. The various parts of a programme influence each other. Increased unification . . . where teachers, students and administrators are working toward common goals, is suggestive of a higher degree of relatedness (1977:11).

Accountability is defined as:

> The extent to which the programme teaches the student nurse that the primary responsibility in nursing is to the patient. (The term "patient" denotes a basic unit or situation to which a nurse responds in providing nursing: . . . the basic unit may be a family, a group, a ward unit, a community, or country) (1977:11).

The core concept of accountability is "how the student learns to

develop nursing action as a response to a particular patient"(1977:12) (patient understood in the broad sense above). "Learning to nurse might be described as a problem-solving process; teaching must seek to provide conditions that enable students to interact with patient situations in a problem-solving way." (1977:25) The learning processes therefore form the base for the student's learning of responsibility and accountability towards the patient for her own nursing practice.

> Nurses must be accountable for shaping the path of nursing in the building of new health services. To do so demands understanding of the fundamental nature of nursing . . . Educational institutions, as the forerunners of change, can demonstrate accountability in guiding the evolution of nursing and of nursing services" (1977:13).

The goals and experiences in a program may be entirely geared to procedures, acute and custodial care, according to a medical model of nursing in which the nurse's role is perceived purely in terms of an extension or assistant to the physician's role. Allen argues that this constitutes a failure of accountability in teaching the student to understand the unique role of the nurse. The trend in nursing, as a response to the health needs of society, is away from the "medical model" with its emphasis on disease towards a health-promotion model that centres on assisting the patient (in the broad sense) in whatever the situation demands to promote, maintain, or recover, health.

Long-term outcomes can be evaluated through evidence of the employment situation, the quality of the graduates' performance, the

outcomes for the community's health status, and the viability of the program itself (1977: 47). From a Community Development point of view, it is most significant to consider the outcome on the health of the community. Allen suggests the choice of two or three target variables as tracers to observe over a three to five year period. Variables such as two major health problems, two potentials for positive health, or two critical health hazards might be chosen in a community where the program's graduates are nursing. Qualitative and quantitative statistics on the use of health services in the particular community may also be useful. In a truly community-based program, the target variables will have been identified in the implementation stage of the program by the community itself. The evaluation will be most useful if it is integrated into the planning process from the outset as discussed above.

These criteria will be used in Chapter IV to compare various case studies of more or less community-based approaches to nursing education, to assess which examples seem to be most effective from a nursing point of view. The criteria may also be used at a more theoretical level to compare the community-based and institution-based models as such. Information for the evaluation of long-term outcomes of the case studies is not available to the author, but in principle such evaluation is possible. The availability of such data would itself be a positive indication of a community-based approach.

The Historical Trend

In summarizing the history of nursing education, a clear trend can be observed, from hospital-based to university- and college-based to community-based. As a more sophisticated pedagogical awareness has

informed the teaching of nursing, the design of learning experiences has become more sensitive to the need to be relevant, accountable, and related. As nursing practice has moved away from a medical model, it has become less narrowly preoccupied with hospital-based acute care, and includes in its wider scope a range of preventive and health-promotion concern whose natural setting is beyond the walls of hospital or college. Learning experiences relevant to these wider concepts of the nursing role are to be found in homes, clinics, work-places, senior citizen's homes, schools, and street-corners: wherever people live. Health education and promotion, disease prevention and the social planning of public health, rehabilitation and management of common disabilities and illnesses, life-style management and long-term therapy, mental health and nutrition, are all best understood and practised in the community milieu.

Hospital-based training of nurses is clearly directed at filling the staff needs associated with acute care in the hospital setting. Community college settings are not necessarily more community-based in their approach; learning experiences may still be limited to hospital settings, and the role that is assumed and modelled for the nurse may be a purely hospital role, that ignores the increasing diversity of nursing roles in the community, and especially in remote communities. The goal of a bachelor's degree in nursing to enter practice, recommended by provincial nursing associations by the year 2000, implies the shifting of educational resources into the university realm, but the campus increasingly includes the community by extension.

This chapter has provided an extensive survey of the fields of

health delivery and education from an historical-structural perspective. Some of the problems associated with health delivery have been analyzed in terms of dominant power relationships. Some solutions have been reviewed which propose placing more power at the community level. The historical trend in nursing education has been examined, and shown to be in keeping with a movement towards more community-based approaches to curriculum, pedagogy, and administration. Criteria have been derived from the discipline of nursing which can be applied to the evaluation of case studies to determine whether, in fact, community-based programs of nursing education fulfil more effectively the needs of health care.

CHAPTER IV: CASE STUDIES

Introduction

In this chapter, selected cases of attempts at innovative change in nursing education for native communities will be described and discussed in terms of their history, administration, funding, curriculum, students and outcomes (if known). The cases will then be compared as to their tendencies towards the community-based or institution-based model. Then the cases will be evaluated from the point of view of nursing education, using the three criteria described in the previous chapter: relevance, relatedness, and accountability (Allen: 1977:11). Finally, the nursing evaluation will be correlated with the community-based classification.

The following cases will not be rigorously evaluated in depth, although it would be feasible to do so in a separate study; each one could provide a major study in itself. Long-term studies could be done to evaluate the impact of each programs' graduates on the communities and institutions where they work. Comparative studies on attrition and retention rates could be a fruitful aspect to examine. The purpose in this study is to assess the cases, using criteria from the nursing discipline, as to whether nursing education can be provided using a community-based approach. A further purpose is to discover whether the cases are in fact demonstrating a community-based approach.

This paper will describe several attempts to educate nurses to serve specifically native constituencies:

Mature Student Program, Brandon, Manitoba;
Attempted Program, K.C.C., The Pas, Manitoba;
Northern Nursing Diploma Program, Thompson, Manitoba;
Inner City Nursing Project, Red River Community College, Winnipeg.

Navajo Community College, Tsaile, Arizona;
Oglala Sioux Community College, Pine Ridge, South Dakota;
Blue Quills Nursing Project, St. Paul, Alberta;

The author has consulted printed resources on history and curriculum, supplemented by personal visits and interviews with faculty in all cases except the Navajo Community College, and was herself involved in a precursor of the Northern Nursing Diploma Program in Northern Manitoba.

Manitoba Cases

This thesis suggests that a Community Development approach is feasible and desirable in nursing education for northern Manitoba. It is apparent that there is a need for nurses in northern Manitoba. In 1981 there were a total of 334 active practicing registered nurses in northern Manitoba (including Thompson area) with a projection of 391 for 1983 (See Table 1). In Manitoba Region there are approximately 100 nursing positions providing service to treaty Indians. In the North Zone there are 34 nursing station, 4 health centre, 9 hospital, and 3 supervisory, positions. About the same numbers apply in the South Zone. Community nursing positions exist in the provincial sector which is responsible for non-treaty and non-native population. In The Pas and area this amounts to 11 provincial positions. The local hospital in The Pas has 38 full-time RN positions. Two of these positions are currently filled by nurses of Cree heritage. In total, there are 150 active RNs in the Norman Region (excluding Thompson area). In 1981, Manitoba diploma schools of nursing graduated 316 RNs and the University of Manitoba School of Nursing graduated 60 BNs, most of them destined to work in the South (See Table 2).

TABLE 1: NUMBER OF ACTIVE PRACTISING REGISTERED NURSES 1975-81 BY MANITOBA HEALTH REGION AND PROJECTED NUMBER OF ACTIVE PRACTISING REGISTERED NURSES 1982-85 BY MANITOBA REGION

REGION	1975	1976	1977	1977	1979	1980	1981	1982	1983	1984	1985
CENTRAL	374	391	417	394	500	503	498	511	528	545	562
EASTMAN	240	237	240	276	296	280	323	324	322	331	339
INTERLAKE	241	254	255	265	296	305	315	312	319	325	331
NORMAN	338	370	346	329	357	332	334	370	391	413	430
PARKLANDS	233	244	240	255	280	282	279	283	293	301	310
WESTMAN	799	885	841	852	930	971	967	1008	1038	1068	1099
WINNIPEG	4259	4482	4440	4568	4787	4875	4958	5177	5379	5582	5770
MANITOBA	6484	6863	6779	6939	7446	7548	7674	7985	8270	8565	8841

(Source: Manitoba Association of Registered Nurses Registry; May 12, 1976; October 1977; November 1978; November 1979; January 1981; September 1981.)

TABLE 2: NUMBER OF GRADUATES OF BACCALAUREATE PROGRAM 1975-81 BY PROVINCE AND CANADA, AND PROJECTED NUMBER 1982-85 BY PROVINCE.

PROVINCE	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
MANITOBA	73	74	83	84	60	67	64	60	63	85	76
B.C.	94	95	108	146	159	196	192	199			
ALBERTA	134	144	132	174	139	168					
SASK.	66	61	52	58	67	67					
ONTARIO	278	358	390	420	365	391	347				
QUEBEC	173	153	198	203	208	213					
N.B.	66	105	105	105	105	105	105				
N.S.	68	57	73	73	73	73					
NFLD.	24	60	37	37	37	37					
CANADA	976	1087	1193	1236	1213	1317					

(Source: Statistics, School of Nursing, University of Manitoba)

It should also be apparent that there is a need for nurses trained specifically for northern service. The turn-over of nurses in the North is very high. In 1983, the average length of stay in Medical Services, Manitoba Region, was eleven months, or an average of over 100% turn-over per year; at the time of writing (1985) the length of stay averaged seventeen months. It is felt that this improvement reflects the tighter economic situation in the country with consequent lack of job opportunities. (source: conversations with Regional Nursing Officer, Manitoba Region, Medical Services, and Personnel Director, The Pas Health Complex, January 1985).

In Canada in the late sixties and early seventies, there was a widespread attempt to move nursing education programs out of the hospital and into educational institutions, as described in Chapter III. In Manitoba, this trend was observable in RN education. Out of six programs, four are still hospital-based, and two are in educational institutions: Grace Hospital School of Nursing, St. Boniface Hospital School of Nursing, Brandon General Hospital School of Nursing, Misericordia Hospital School of Nursing, University of Manitoba School of Nursing, Red River Community College.

Three other hospital schools closed prior to establishment of the Red River program. Brandon General Hospital spear-headed the first attempt to produce more native RNs with its Mature Student Program, which is now being phased out. The other two Manitoba programs, the Inner City Project and the Thompson Northern Nursing Program, are linked by extension with Red River Community College.

In the mid-seventies, several currents for change were converging in Northern Manitoba towards realizing the need for a community-based

nursing education program to meet northern, primarily native, needs.

In 1976, the Manitoba Association of Registered Nurses (MARN) issued a document Nursing Education: Challenge and Change proposing future directions for nursing education. Recommendation #7 reads:

> That, as soon as it is feasible, there be initiated an experimental nursing education project to prepare technical practitioners in the North, incorporating the use of modern transportation methods, technological aids, and satellite educational stations (Manitoba Association of Registered Nurses: 1976: 163).

Concurrently, meetings were taking place within Medical Services Branch (Health and Welfare Canada) stimulated by researcher and University of Manitoba nursing faculty member Mona McLeod. Medical Services, responsible for staffing nursing stations on reserves, was faced with a high turn-over of personnel in remote native communities. The average length of stay for nurses with Medical Services, Manitoba, was under one year. Nurse practitioner programs of one to two years in length were available at some universities in Canada. Medical Services could see the value of educating indigenous nurses in reserve settings, with competence at the baccalaureate level to deal with the varied independent judgments required in remote communities.

This led to a formal meeting of the "On-Reserve Nursing Training Committee" in January 1977, representing Medical Services, federal Department of Indian Affairs and Northern Development, provincial Departments of Northern Affairs, and Continuing Education and Manpower, and the University of Manitoba School of Nursing. This group functioned as a steering committee, producing a draft proposal for a Bachelor of Nursing program and circulating it to such groups as the Manitoba Indian Brotherhood.

In 1977, a Joint Ministerial Task Force on Nursing Education was established by the Government of Manitoba. A joint brief of the Manitoba Indian Brotherhood (MIB) and the Manitoba Metis Federation (MMF) was presented to the Task Force (This brief was quoted in the Introduction:7). The MIB and MMF proposed the establishment of a school of nursing which would be operated under the control of a Board composed of Indian and Metis representatives. As well as traditional nursing subjects, this school would provide courses in community health, native language and culture, and cross-cultural nursing.

Attempted Program at KCC (The Pas)

Keewatin Community College (KCC), The Pas, the only post-secondary learning institution in Northern Manitoba, had been operating a ten-month training program for Licensed Practical Nurses (LPNs) since 1972, as well as a twenty-week training program for Community Health Representatives (CHRs). Some faculty members at KCC, as well as a large number of LPNs at the local hospital, wanted a one-year post-LPN program to up-grade LPNs to the level of Registered Nurses. The hospitals in the area had expressed the need for training more RNs to serve in the urban population centres. The hospital in The Pas was faced with very high annual turnover of nurses. There were suggestions of a "career-ladder" approach that would produce CHRs, LPNs, and RNs in one program with several levels and "exit points". This training would all be largely institutionally based, however, and would not meet nor prepare students for special needs of remote communities.

In 1978, in response to the proposals for a community-based program to prepare native nurses, the provincial and federal

governments provided funding to develop a feasibility study, based at KCC. A broadly representative Advisory Committee was set up and a consultant was hired to develop a curriculum model. The author was aware of these developments from a distance, and made the following observations, in keeping with the dialectical framework of this thesis:

> At this stage, one might expect some problems in such a diverse group working together, especially given the innovative character of the proposals. There is no nursing education program in Canada at present that does not rely heavily on hospital settings for the major learning experiences, although both WHO and CNA guidelines suggest a more community-based approach. Thus, within the MARN, (sic.: Manitoba Association of Registered Nurses) . . . one might expect some conservatism, despite the amount of leadership that has come from within MARN circles to date. On the other hand these legal constraints may be counter-balanced by the political weight of native representation . . . To overcome these hidden tensions, the first phase of the planning process will have to deal with clarifying the different goals and values of the participating bodies . . . The danger from this writer's point of view is that the program could be developed without sufficient reference to the needs and hopes of the people being served, leading to what would amount to an imposed curriculum based on older models (Author: unpublished paper: 1979).

These remarks turned out to be prophetic. The Advisory Committee was not happy with the direction development took, in that it was not community-based, did not provide for adequate learning experiences in and of the local communities, and seemed to provide traditional hospital-oriented direction for the program.

In 1980, new development funding was acquired through the federal Department of Regional Economic Expansion (DREE) as part of the Northlands Agreement with the Province of Manitoba. The objective was to develop a curriculum that reflected a community-based philosophy,

under the guidance of the existing Advisory Committee at KCC. The author was hired in July 1980 for a term appointment as Program Coordinator. Staff from the provincial Department of Education, Program and Evaluation Branch, were assigned to help develop curriculum. With the Coordinator, a general three-year curriculum was outlined, with a detailed first year. Upgrading was to be integrated with the nursing curriculum thoughout the three years, according to individual need, rather than concentrated in the first year, as in the Brandon model; thus, the "praxis" (cf. Freire) would produce literacy.

The Coordinator visited a variety of northern native communities to discuss the proposal with local leaders, and explore local resources for community-based learning experiences and facilities. The chief of The Pas Band expressed some misgivings about an innovative program designed especially to meet native needs, on the grounds that it might turn out to be a "second-class program". Some other chiefs expressed the view that high-school graduation should be an entrance requirement, as they had a growing number of graduates in their communities, with little "close-to-home" opportunity for post-secondary education. The only professional training program available in the communities was the Brandon University Native Teacher Education Project (BUNTEP), which provided a positive model. Several communities made concrete proposals for hosting the program.

However, the major problems for the development of the program came from the unresolved tensions referred to in the author's observations on the earlier situation. There were forces of opposition to this type of program within the Community College itself, and within the nursing community at large. These interest

groups wanted a program aimed at the need for hospital staff in the larger communities, and the need for LPNs to up-grade themselves to RN to fill a hospital role. College staff were also skeptical about the abilities of native students, and the workability of the community-based approach to up-grading and instruction; they tended to view the program as "imposed" from Winnipeg. This view was epitomized by the new College Director who assumed his role two months after development of the community-based model had commenced. These tensions continued unresolved behind the scenes, while the Coordinator's time and energy was entirely consumed with curriculum-planning and establishing contacts with the local communities to be served.

A change in the administration at KCC brought these tensions to the fore. The new administration ceased calling together the Advisory Committee, or permitting staff travel or direct communication with the communities, cutting off the program staff from its community base. Conflict between the program, KCC, and the Program and Evaluation Branch became an obstacle to implementation from the Government's point of view. Funding for implementation for a further fiscal year was not approved, the Coordinator's term expired, and the Advisory Committee was "interrupted" (Letter: Asst. Deputy Minister, Education: 1981).

Further Proposals in Northern Manitoba

From 1981-84 the author has been employed as community health nurse for The Pas Band. At an initial meeting with the Band Council, one Councillor asked "How can we develop our own people to be nurses?" In a subsequent meeting with the Chief, a number of questions were

raised by him:

"We've had three people go away to learn nursing. Why don't they return to work with Indian people?"

"Why can't we have our own hospital and our own ambulance service?"

In January 1982, a proposal was drafted seeking to establish a Bachelor of Nursing (BN) program as a satellite of the University of Manitoba, but with a local governing board. A Band Council Resolution was passed, and letters sent to various native, professional, and political organizations. The concept was explained in the Band's community newspaper, and potential interested students solicited. Eighteen names were kept for future reference.

Nursing duties kept the author so busy that further follow-up did not take place. A dormant Health Committee was reactivated at the end of 1982 under a new chairman, one of the Band Councillors. In November 1982, a new Northlands Agreement was signed between the federal and provincial governments (the previous agreement having expired in 1980). It was decided by the Band Council that funding for a BN program might better be achieved if the proposal went under the auspices of the Swampy Cree Tribal Council (SCTC). In March 1983, the SCTC Board, comprised of the seven chiefs from the bands in The Pas region, passed a resolution to seek funding for the program under the Northlands Agreement. To date, this has not been achieved. In December 1984, an application for funding the project was made to Medical Services Branch, under a new Indian and Inuit Health Careers program; this is still under consideration.

Mature Student Program (Brandon, Manitoba)

This was a pilot project initiated in 1976 by the Brandon General

Hospital School of Nursing in cooperation with the Post Secondary Career Development Branch of the Manitoba Department of Education. Intakes of students took place in 1976, 1979, 1980, 1981 and 1982. The program "was designed to provide an opportunity for R.N. Diploma nursing education for mature students with cultural, educational or financial disadvantages." No other opportunities existed at the time that were specially for native students. The federal-provincial Northlands Agreement provided funding to the program on condition that two-thirds of the students be of Indian ancestry, and 60 % be from northern regions.

"The design of the program varied from group to group, as we experimented and adapted to the changing student group" (Letter from Program Director: Feb., 1984). Generally, the group was taught separately for a special preparatory year, and those who continued were combined with regular nursing classes in the two-year R.N. Diploma course at the hospital school.

The preparatory year included courses specially prepared for this purpose, which have been used in other programs developed since then. The first year included development of study skills, introductory science, interpersonal relationships, and required University courses.

"The major disadvantage of the location in Brandon was the need for students to relocate. This meant that many were long distances from their home communities" (Ibid.: 1984). The hope was expressed "that the newer community based programs can reduce the difficulties related to relocation". Considerable attrition seems to have taken place, and distance from home communities is the major explanation cited. The program is now being phased out.

A total of sixty-nine students were admitted; of these, forty (58%) left the program without completing at least the L.P.N. level. Fourteen graduated as R.N. (four native), seven as L.P.N. (four native), and five are still enrolled (three native). One third of the graduates left the program early by taking advantage of a "career ladder" arrangement with Assiniboine Community College allowing them to apply their credits to the requirements for L.P.N. Some of those who left the program after the first year transferred to other programs at Brandon University or the University of Manitoba, so the preparatory year is seen as serving a useful purpose even for those who switched to other studies (Ibid.: 1984).

By June 1984, after five intakes of students totalling 69, only 6 native students had graduated from the RN level and 5 at the LPN level. Two of the native RN graduates and one LPN are working in northern hospitals and one RN in a southern hospital. The whereabouts of the others are unknown to the faculty, suggesting a lack of follow-up (phone conversation with Shirley Paine, Nursing Education Program, Brandon: 1985).

Inner City Nursing Project (Red River Community College, Winnipeg)

This three-year program was initiated in 1981 by the Post-Secondary Career Development Branch, Manitoba Department of Education, the body responsible for innovative programs, particularly to provide access to disadvantaged groups. The purpose of this program was to provide access to an RN diploma nursing program for mature students from the city of Winnipeg with cultural, educational or financial barriers. The initial intake of 15 students was predominantly Canadian Indian, with a cross-section of immigrant

groups. The first year funding was through a joint federal-provincial agreement, the Core Initiatives Fund, for inner-city development in down-town Winnipeg. It is worth noting that our inner cities are now major centres of native population.

The curriculum was planned to provide an upgrading opportunity in the first year, in communication skills, social and physical sciences. The program had a staff of two for the first two years, who coordinated courses in reading and communication skills, nursing and basic sciences, and native studies. At the end of the second year, 1984, eight students received certificates as LPNs, and are continuing for a final year to complete their RN studies. Six other students are repeating some term work or taking time out to deal with personal problems, but have not been lost to the program. This represents a very high retention rate in the first intake of students. At the beginning of the third year, a third staff position was added, and a second intake of students took place in the Fall of 1983. The group's ethnic background is even more broadly cross-cultural but still predominantly native: Indian, Inuit, Vietnamese, Filipino, German, Jamaican. Group Dynamics and Life Skills have been added to the curriculum. During the summer, a Sociology course was taken by the students at the University of Winnipeg's downtown city-centred campus.

Funding for the program was received on rather short notice, resulting in a short recruiting period for the first student intake. At that time, there were between 50 and 60 applicants, but by the time of the second intake there were over 140 applicants. After the program started, at the request of the program staff an Advisory Committee was formed which includes representatives from MINA

(Manitoba Indian Nurses' Association), the College's regular nursing faculty, and the Manitoba Indian Education Association. This committee's task is to act as a resource to the program, and to advise on such matters as student selection.

Northern Nursing Education Program (Thompson, Manitoba)

This three-year RN program was implemented in Thompson, the largest centre in northern Manitoba, with the first intake of students in January, 1983. It is designed to provide admission to the Red River Community College nursing curriculum by extension, for northern people with social, economic, cultural, academic and geographic barriers to opportunity. "Year 1 provides non-credit, courses in reading and writing remediation, study skills and a basic Math/Science course designed specifically for nursing students" (Student Application Form: 1982). Individual tutoring is available as necessary. It is planned that in Years 2 and 3, clinical experience will be obtained in hospitals and nursing stations.

Personal supports are available according to need for counselling, housing and day-care. Students are selected on the basis of greatest need: lack of financial resources, lack of educational preparedness, and remote location. Although the recruiting time for students was short, 180 applications were received, from which 18 students were selected. Funding is provided by the Provincial Government for student allowances, tuition, books and uniforms, as well as program expenses. The staff of six includes two people of native ancestry from Manitoba.

Blue Quills/Grant MacEwan Community College Program

This three-year RN program was initiated in 1980 by the Blue

Quills Native Education Council located near St. Paul, northern Alberta. Blue Quills College had previously brought three professional programs by extension from various Alberta universities (teacher education, social work, and administrative studies). The nursing program received 100% funding as a Pilot Project from Health and Welfare Canada. The educational program was provided jointly at Blue Quills and Grant MacEwan Community College in Edmonton. A maximum of twenty students were to be accepted into the nursing program. The project coordinator was to be a joint appointment between the two educational institutions. The plan was that from September 1980 to June 1981, Adult Basic Education courses would be taught as well as Native Studies elective courses. The students, however, continued on at Blue Quills until January 1982, when they qualified to enter the Grant MacEwan regular students program. Native Studies was not a required course in the program at that time.

The concept of this program was to use Blue Quills as a "field centre" (Blue Quills Diploma Nursing Proposal:1980) which would be closer to students' homes, and which would "provide the social and cultural support system for students . . . gradually to ease their way into post-secondary education". As it happened, in the first run-through of the program students remained at Blue Quills for eighteen months. This had the effect of shortening their time in the nursing courses at Grant MacEwan. Coupled with adjustment difficulties in coping with the urban environment and nursing courses, 9 students (5 native) were expected to graduate in 1983 out of the original 14 that moved to Edmonton. Individual tutoring was available

for students, and drill was required to learn to write multiple choice examinations. Over 30 students entered Year I in this pilot project but, according to the current coordinator, they did not receive adequate counselling about what the course requirements were, and therefore lacked proper educational preparation for entrance into the college nursing program.

It is envisioned that in the next group of students, Psychology, Sociology and English, as well as Life Skills and Native Studies course options will be required in the first year. Students will remain at Blue Quills for the first trimester of Year II, for Anatomy and Physiology, Nursing Fundamentals and Interpersonal Aspects of Nursing, as well as Clinical Practice I. On the move to Edmonton, the first course taken would be Obstetrics, as this would be an area of study and practice in which students could build on prior knowledge and experience (Interview with Program Director, March, 1983).

The first group of nine graduates was in 1983, with five native students amongst them. (Fourteen total had started out in 1980.) Of these five native graduates, only two passed the RN exams, and both went to work in northern hospital settings. One later went to work in a community setting on a reserve. The three other graduates have attempted and failed the RN exams a second time (leaving one more chance to pass). According to the Coordinator, their problems on the exams revolved around difficulties with mental health concepts and vocabulary. These had presented problems earlier in the program because of cross-cultural differences. Two earlier native drop-outs returned this past year (1984). One of these completed and passed her RN exam. The second is still completing her studies. They and the

other three graduates are all working in small hospitals near reserves. If they finally pass their RN exams, there will be a total of seven native RNs out of the original fourteen students, and an over-all completion of eleven. This is a good completion rate, and reflects the intensive tutoring given individual students, as well as high motivation and intelligence on their part (Phone conversation with Program Coordinator, January 1985).

Oglala Sioux Community College (Pine Ridge, South Dakota)

This college has two Centres, the Pine Ridge College Centre, and Sinte Gleska College Centre at Rosebud, S. Dakota. Each College Centre offers courses by extension to six or seven surrounding communities. The Pine Ridge Reservation is about one sixth of the area of the State of S. Dakota, and has a population of about 15,000.

In 1970, the Director of the Nursing Department at the University of S. Dakota and the Director of Pine Ridge College Centre met to discuss the concept of a "community-centred nursing education program" on the reservation.(History of the Associate of Arts Nursing Program, Renewal Proposal:1979). An Advisory Council was set up in 1971, comprised of public health nurses on the reservation, community health aides, the tribal health board, the reservation hospitals, and the community-at-large. The entire funding was obtained from the federal government's Indian Health Services, and additional funding was sought from the National Institute of Health and the Bureau of Indian Affairs. In the early years, Pine Ridge was operating on annual grants, and one year received no funding. The first class was started in 1973 and was located in a mobile trailer.

The College Centres were founded upon the philosophy of Indian

control and determination of their own destiny. Those Indians who had left the reservation for higher education either dropped out and returned home, or succeeded but did not return. The College believed it could assist in three areas of native career development:

1. Provide a bridge for Indian persons to non-Indian institutions and skills so that the Tribe need not depend on outside, non-Indian expertise;
2. Provide career development programs to develop middle and upper management personnel;
3. Provide general non-credit programs and workshops to up-grade the general level of educational skills on the reservation;

The model they used they called a "dispersal model"; with the activities of the extension course, they felt CD would be maximized.

The curriculum at Pine Ridge is a two-year course requiring a G.E.D. certificate for entrance. It is a satellite program of the University of S. Dakota but operates quite autonomously on the reservation within the native-operated Oglala Sioux Community College. Its curriculum is that of the Associate of Arts degree program of the University and does not include Indian culture as such. During a visit this author made to Pine Ridge in 1981, the Director pointed out the need in this program for culturally-relevant course work in the nursing education curriculum; however, she felt there were time constraints on staff's accomplishing this major revision. The course has a student population combined of native and non-native students, the rationale being that distance and cost prevented most potential students in their area from travelling to a larger centre for their nursing education.

The goal was to offer the entire curriculum on the reservation, with the exception of field trips to specialized treatment centres. The program used the same curriculum as the Associate Arts (Nursing) Diploma of the University of S. Dakota, and was established as a satellite of that program, but with a local governing council. Native studies and the Lakota language are course options available from the larger college program.

The statistics of retention rates during the early years reveal the growing pains of the program at the Pine Ridge Centre. Six students were enrolled the first year (1973-74). Of these, five dropped out, and one repeated. In the second year, eight students enrolled and four remained to graduate in 1976. Since then, there has been a steady improvement in the statistics, especially during the two years preceding the author's visit, coinciding with the current Director. One of the problems described to the author during her visit was that the previous nursing program director did not support the goal of helping the survival of the Lakota language and culture. Between 1973 and 1980, a total of 69 students enrolled; 28 of these dropped out, 31 graduated, and 10 were still studying. During the years 1979-80, there has been a 90% retention rate. Of the 31 graduates, 19 passed the State Board RN examinations on the first try. (Three attempts are allowed at these exams). Twenty-nine of the graduates were employed in health occupations, 10 on-reserve, 12 off-reserve, and one in further study. Of these 31 graduates, 9 were non-Indians.

The following implications may be drawn from the above program:

1. Any new programs of nursing education designed for native

communities should consider building cross-cultural studies or learning experiences into the curriculum from the beginning.

2. There should be flexibility in the curriculum to meet individual student needs.

3. Financial anxiety affects the learning environment of both faculty and students; assured funding should be in place for the life-time of the program.

4. Despite financial uncertainty, the program is in place; one should not wait for perfect conditions to implement a necessary program.

Navajo Community College (Tsaile, Arizona)

The college is concerned with "furnishing a sound basic education in a familiar environment for the student who wishes to go on to a four-year college or university". It has "integrated Navajo studies and philosophy into the general College curriculum" (College Calendar: 1978).

This college was the first Indian-owned and operated, fully accredited college on an Indian reservation in the U.S.A. It was established in 1969, after Navajo students experienced a high drop-out rate in off-reservation programs. The on-reserve college was seen to be a bridge over the cultural gap between the Navajo and non-Indian worlds. The governing ten-member Board of Regents is all-Navajo. Classes began on the new campus at Tsaile, Arizona, in 1973. Extension classes and outreach programs exist for Navajo in the states of Arizona, New Mexico and Utah.

The early years of the college were marked by a constant struggle to obtain operating funds. Now, the U.S. Government provides the basic operating funds. The college views its responsibility as to

serve the 140,000 Navajo population spread over a land area of 16,000 square miles. The average adult Navajo has completed five years of schooling.

Major assumptions can be gleaned from the Navajo College's statement of philosophy and purpose.

1. It is essential that the educational systems be directed and controlled by the society they are intended to serve;
2. Each member of the society must be provided with an opportunity to acquire a positive self-image and a clear sense of identity; it is necessary for all individuals to respect and understand their culture and heritage, and to have faith in the future of their society;
3. Members of different cultures must develop their abilities to operate effectively, not only in their own society, but also in the complex of various cultures that makes up the larger human society;
4. The college must search out and test new approaches to dealing with old problems and respond effectively to problems arising out of rapidly changing conditions;
5. The college accepts the responsibility of providing individualized programs and assisting students with their academic and social adjustment.

The college includes a two-year nursing education program with the following entrance requirements: a high school graduation transcript or a G.E.D. certificate, an S.A.T. Reading Acheivement score of 10.5 or better, an S.A.T. Mathematics Acheivement score of 9.5, an interview detailing goals, interests, and social and/or family constraints, a satisfactory physical examination, and a passing grade in high school Chemistry. Navajo aspects are included in all nursing subject areas,

as well as Navajo leadership and language skills.

The Navajo College arose because of problems students faced when going away to study. Originally, scholarship funds were raised locally to send qualified students away, but the drop-out rate for these students was unacceptably high. The College offers a variety of technical programs, and Navajo students are required to study Navajo language, while non-Navajo are required to study Navajo history and culture.

There is a conscious intention to preserve Navajo knowledge and values and to transmit these to students. Private funds are acquired for the College through bequests and foundation grants, although the Federal Government covers the basic program costs. The geographic area of the reservation is large and courses are available by extension for students who do not wish to relocate to the College campus. The development of a leadership role for the nurses is assumed by providing Navajo approaches to leadership in the curriculum.

The six credit hours of Navajo studies, utilizing Navajo resource people, makes up one twelfth of the 72 credit hours in the nursing program. This appears to meet the goals of sensitizing students to a variety of cultural expressions, and developing pride and understanding of their own culture.

Local control of the College is demonstrated with an all-Navajo Board of Regents and an historic succession of Navajo presidents. From a view of the history, goals and curriculum design (the only data available) a conclusion may be drawn that this program exemplifies a community-based approach. It contributes to the educational, health, and cultural development goals of the community. As well, it

demonstrates the development of an educational institution which reflects and nurtures the needs, goals, feelings and interests of the community of which it is a part.

Since 1972, there have been 46 RN graduates. Of these, 31 are Navajo, 4 are from other American Indian tribes, and 11 are of other ethnic backgrounds — black, hispanic, and anglo. 33 of these graduates are employed by the Navajo Nation on-reserve, and 5 have gone on to complete their Bachelor of Nursing degrees. The attrition rate is about 50%. This problem has been addressed in the 1982 intake of students, whereby a year of up-grading is provided prior to final selection into the nursing program (Phone conversation with Instructor, December, 1984).

Classification: Community-Based or Institution-Based

We recall the definitions given in Chapter I:

Community-Based Approach and Community Development

The term "community-based" refers to an approach which seeks to develop a specific community (either a geographic community or a community of interest) in such a way that the common goals, feelings and interests of the people will enable and support development to meet their own needs. This includes the identification of local resources and strengths, and the acquisition of those resources which are not present in the community but which are seen as essential to meet its development needs. Thus, a community-based approach to development is the utilization of the community's indigenous and acquired resources as a means to the community's own goals. Such an approach is commonly referred to as "Community Development".

Institution-Based Approach

The term "institution-based" refers, by contrast with "community-based", to an approach in which the needs, goals and resources of a particular institution shapes the formation, administration, accountability and evaluation of a program. The institution may be a part of the local community, or it may be a larger institution of society with local delivery systems, but is relatively independent of the local community. These two approaches represent ideal types, at opposite poles of a dialectical continuum, which can be used to analyze particular case examples.

It will be necessary to specify some features from these definitions which can be used to compare the case examples as to where they fall on the continuum between community- and institution-based.

The following criteria reflect the community-based approach:

Local Control and Administration:

1) Need identified by local community;

2) A demand for this kind and level of practitioner:

(a) current, (b) projected;

3) Representation from the community on a decision-making Board with ultimate accountability, at all stages of development from needs identification, through planning and implementation to evaluation;

Local Resources:

4) Utilization of local resource-people in teaching;

5) Utilization of local facilities for teaching space;

6) Potential for acquiring needed outside resources;

Locally Developed Curriculum:

7) Utilization of a variety of local settings for learning experiences

in the community: schools, senior citizens homes, day-care centres and nurseries, hospitals, nursing stations, public health centres, physician clinics, chronic care facilities; and other special interest service agencies;

8) Consultation with community agencies in the formulation of learning objectives;

9) Addressing predominant health needs in the region through the curriculum, both theory and practice;

10) Respect for local culture(s) and cross-cultural communication in the curriculum;

Equal Access:

11) Equal opportunities for people of various cultural and economic backgrounds among the students;

By contrast, the following features reflect an institution-based approach:

Institutional Control and Administration:

1) Programs developed to meet needs of institution rather than community; need to redeploy permanent teaching staff may create new programs;

2) Administrators making decisions about the continuation of programs, with little accountability to community;

3) Little local participation in decision-making Board; or decision-making vested in Government Department at some distance from the local community;

Institutional Resources:

4) Little use of non-staff local resource people or facilities;

5) Program shaped by imposed funding restraints decided elsewhere;

Institutional Curriculum:

6) Curriculum imposed as an "ideal type", developed elsewhere, not adequately adapted to the local context, or the local students.

7) Learning experiences are not broadly based in the community, and are not developed in consultation with agencies providing experience;

8) Local culture, and cross-cultural communication, ignored;

Equal Access:

9) Students recruited to fill maximum number of "slots" in a class, without attempt to allow for equal access of disadvantaged.

General Comparison of the Case Studies

This section will compare the case studies with respect to their human, material, organization and curriculum resources, with a view to assessing how community-based the different programs are.

Administrative Resources: As far as the administrative organization of the programs, the Navajo seem to have the most local autonomy under the Navajo Board of Regents of the College. The Oglala program is also under the Board of its own community college. Blue Quills started out under the educational authority of the tribal council in North East Alberta, but at the time of investigation (June 1983) there appeared to be conflict between the native education authority and the urban college nursing program, which controls the later stages of the curriculum. Both the Winnipeg Inner City and the Northern Thompson program are under the administration of the urban community college in Winnipeg and derive most of their curriculum from the college. After the first year, the staff of The Inner City program requested formation of an Advisory Council with representatives from the Manitoba Indian Nurses Association and other

native groups. There is an Advisory Council for the Thompson program, but according to one of its members, it has not been active since the selection of the first intake of students. It seems these representatives were not involved in the decision-making. The advisors came from the Post-Secondary Education Branch of the Manitoba Department of Education. The Brandon program operated under the direction of the School of Nursing.

Human Resources: The ratio in all the programs of faculty to students seems to be between 1:5 and 1:8. The number of students in the Canadian programs is strikingly larger than in the US programs. The American directors all mentioned the financial straits of their students, which is probably the major reason for lower enrolments. They noted the need to provide time for the students' part-time jobs and summer jobs to finance themselves. The Canadian students are well-funded and supported to look after their financial, personal and family needs. A major goal of all the Canadian programs seems to be to provide additional opportunity to disadvantaged students -- those disadvantaged by geography, finances, or culture -- to find an opportunity in nursing. Therefore the financial barrier is intentionally alleviated. Both the American and Canadian programs have a mixture of native and non-native students. The non-native students seem to be similarly disadvantaged groups sharing similar barriers from participating in regular nursing programs.

Educational Resources: Whether explicit or implicit the philosophy of all programs is to provide a bridge for the students for transition from their own cultural background to that of the professional nurse.

All programs appear to be oriented to the small group learning experience. The American programs admit about 8-12 students, the Canadian admit about 16-18 per year. Regarding inclusion of traditional knowledge in curriculum content, the Navajo (the oldest program, starting 1973) has the most content relating to traditional knowledge, and is now in transition from emphasis on Navajo culture to a broader incorporation of the cultural backgrounds of other groups of patients, e.g. black, hispanic. The Oglala Sioux have optional courses for students in Sioux cultural content. Blue Quills does not appear to have included any native cultural content as such in its curriculum. The Inner City program is now including resource people from the community for native awareness, and utilizes agencies in the city which deal with native people for learning experiences. Thompson does not appear to have incorporated native content so far, nor did the Brandon program. The Navajo, Oglala Sioux, Thompson and Winnipeg Inner City programs all have native personnel on the teaching staff. The Navajo and Inner City programs utilize other native resource people as well.

Material Resources: The one program that is completely based in a larger educational institution is the Winnipeg Inner City program. Both American programs, the Navajo and Oglala Sioux programs are located right inside native communities. The Alberta Blue Quills program is a mixture, part-time in the native educational institution and part-time in an urban community college. The Thompson program is a satellite of the Winnipeg community college, but is geographically far removed, and has its own building, and is not set within another institution. The Brandon program was based entirely within the school

of nursing; the class began by being a separate group within the same institution, and later merged with the regular program.

In the light of the above criteria, as discussed in the case study presentations, the programs can be placed on a continuum which rates them as more or less community-based or institution-based:

Community-based ---------- Institution-based

Navajo...Oglala Sioux...Inner City...Thompson...Blue Quills...Brandon

Evaluation: Relevance, Relatedness, and Accountability

> A nursing program is regarded as consisting of a number of related parts -- curriculum, teaching of nursing, practice of nursing and research, and administration -- functioning together to achieve common goals or purposes. The values that reflect the development of a programme are thought to be: the relevance of the goals, activities and outcomes of the programme to the particular community or country; the relatedness of the different parts of the programme in seeking common goals and in discovering the means to achieve them; and the accountability of the programme in assuming responsibility for its goals, methods, and outcomes (Allen: 1977:11).

These criteria for nursing education development can be used to assess the cases that have been presented. They can be helpful in showing the validity of a community development approach in nursing education using nursing criteria. The assumption is that the nursing role is a valuable one in promoting health development in a community.

Because many of the programs in the case studies are in their infancy, long-term outcomes cannot be assessed at this point, but are capable of being evaluated in the future as to retention, graduation, and job placement. Some of the programs are old enough for their outcomes to be assessed already. However, the author wishes to emphasize that evaluations for the purposes of this paper cannot be

taken as in any way official or exhaustive. They represent an individual interpretation of what data was readily available, but do not represent an in-depth or systematic evaluation of any one of the programs described.

Brandon Program

Relevance: The goal of this program was to provide access to nursing education for those disadvantaged by education, finances or culture. An anomoly or major contradiction is that 60% of the students came from the North and were dislocated to obtain an education in the South. As a consequence of this location, the relevance of the curriculum to the home setting of the students was minimized. On the basis of problems observed in the previous intakes of students in 1976 and 1979, the 1980 preparatory year was undergoing revisions (conversation with Program Coordinator, Brandon, 1980). The students' motivation had been difficult to maintain, because the literacy course to upgrade reading and writing skills contained irrelevant content. The teachers in 1980 were attempting to introduce material more relevant to the experience of students from native communities.

Relatedness: The curriculum parts were improved to relate better to one another, particularly in the preparatory year. A student who dropped out of this program after two years explained that the communication skills in the first year curriculum did not relate well to the native students; in particular, the instructor's style and emphasis proved to be upsetting to a number of the native students. The counselling supports, she felt, did not really address the day-to-day problems students had to face in their life situations. In

this student's case, the problem was the financial burden involved in transporting her child to a sitter at the beginning of the day, or during shift work, and being alone to face this situation when her husband decided to move back North.

Accountability: It seems that the Government funding was withdrawn because at a time of scarce financial resources, the low output of graduates could not be justified. In effect, the funding was transferred to the Thompson program.

Although intentions were good and it was the pioneer in Canada of this kind of program, the Brandon experience demonstrates the low effectiveness of a program for native students which causes the degree of dislocation for native students from their northern homeland. Conversely, the experience strengthens the argument for learning experiences in the community with readier access to the home-base.

Inner City Nursing Project, Winnipeg

Relevance: This program seeks to be relevant to the needs of the inner city community, including the urban native population that is a significant part of that community. The program's goal is to provide access to nursing education for those who would normally not be accepted by, or not apply to, a regular nursing program because of cultural, academic, or financial barriers. It takes into account the migrant ethnic groups that have settled in the city and recognizes the need for nurses to be recruited from, and developed to serve in, the inner city. It provides an opportunity to the traditionally "underserved" not merely to be cared for, but to be trained to care, thus developing the community's own resources. The opportunity is structured to up-grade underqualified students in the first year, so

that they can enter the usual diploma curriculum thereafter.

Relatedness: Because of the "pilot" nature of this project, there is a generous degree of autonomy for the teaching staff, who still remain accountable to the College administration and the regular nursing program. Many of the learning experiences in the first year (upgrading) provided for an immersion in the city's various service agencies. Communication skills and report-writing were developed within "real encounters". The author was impressed by the level of personal interest and involvement on the part of the staff, which contributes to an integration of all types of learning in the personal development of the students. A rural learning experience is also provided for, and Native studies forms a part of the curriculum, thus helping to relate broader areas of experience to the nursing curriculum (Conversation with Program Teacher: June, 1983).

The courses are sequenced to form a "career ladder" whereby the students obtain a practical nurse diploma at the end of two years (after the first year of the regular program), and an RN diploma after the third year. Students take their Sociology at the University of Winnipeg, whose campus is in the city core; this course also provides the additional broadening and challenge of a university-level course. By including some university credits, a step is also taken in the career ladder towards the baccalaureate level.

Accountability: The students and teachers are both motivated to achieve the goal of graduation; the teachers exhibit a deep commitment towards the students. One of the two teachers is of Indian ancestry and provides the understanding and encouragement many of the students need. A need was felt, half-way through the program, for an Advisory

Committee. This not only increases the linkages or relatedness between different parts of the program, the community, and such groups as the Indian Nurses' Association, but also increases the accountability back to the community.

Since the first group of students is just approaching graduation, it is too early to measure outcomes. From interviews with a teacher, however, it is apparent that students have been provided with a broad range of learning experiences, have learned a problem-solving approach to their own life situations as well as the varied situations of their patients. A high completion rate is predicted. These are indications of an "accountable" attitude towards the patient.

Thompson Program

Relevance: The goal of this program is similar to the Inner City Project: to provide access to nursing education for the disadvantaged, in this case northern residents of remote communities. As mentioned previously, Manitoba has a high proportion of native people living in relatively isolated locations. Since it is hoped many of these graduates will return to their own communites, learning experiences are planned in these communities. The Advisory Committee includes links with native organizations and communities, which should ensure greater relevance to the perceived needs of those groups. However, this single northern-based program cannot be assumed to be serving the whole northern Manitoba constituency. The Advisory Committee is Thompson-based and the students are drawn from the region surrounding Thompson.

Relatedness: A first year provides academic up-grading and adjustment to northern urban living. This program is adapted from the

Winnipeg- based diploma nursing course from Red River College. Conversations with teaching staff indicate problems of communication with the administrative base, 600 miles south in Winnipeg. It is hoped that clinical and field nursing practice will reflect the nature of nursing in this northern region. Plans are for learning experiences in nursing stations in remote communities, as well as hospital and service agencies in the small city where the program is located. At the time of writing, the first in-take of students has just completed their first year (up-grading) and have started hospital-based experiences. Thirteen students remain out of the original eighteen. Two students left for academic reasons and three for personal/family reasons. Six of the above thirteen, one-third of the way into the second of three years, are involved in practice learning experiences in the nursing stations of their home communities.

Accountability: It is premature to assess accountability in terms of the students' learning responsibility towards the patient. The traditional nursing education settings (hospital and senior citizens' home) are the only settings used by the end of Year 1. However, nursing practice in remote communities is underway in Year 2; this should teach a more accountable and confident attitude to the community.

The Advisory Board appears to have been ignored since the student selection process. The distance from the administrative base in Winnipeg creates frustrations for the staff, and implies little accountability for administrative decisions to the local community. There appears to be limits on the sense of accountability to students. For example, one student who had been told by the teaching staff that

she had successfully completed her first year and passed all her tests, and had purchased uniforms and supplies, was later instructed by mail not to return for Year 2 because she had failed an English reading test for speed. This is the student's side of the story.

Blue Quills Community College

Relevance: The goals of this program indicate the desire to prepare students for a professional role in the modern world. The main rationale and relevance of the program is its initial geographic location: "a field centre closer to students' homes . . . to provide the social and cultural support system" (Proposal:1980). There are no stated goals as to the characteristics of the nurses produced, nor the anticipated impact of the nurses on the health of the community. This suggests that the students will learn the role of a nurse that is typical of urban college and urban hospital settings.

The relevance of this nursing program to the health and development of native communities is questionable. Experience with the first group of students has led to some changes in the first half of the curriculum (the part taught at Blue Quills). Native Studies and Life Skills are now mandatory. Life Skills, as explained to the author, was concerned with those skills required to orient the student to life in an urban culture. While the student needs to cope with the modern world, the emphasis still seems to be weak on skills needed for nursing in the native community setting.

Relatedness: The administrative structure sets up the Coordinator to be a liaison between the two learning institutions (Grant MacEwan College and Blue Quills). The decision-makers appear to be the teachers involved in both settings. According to the Coordinator,

there were some difficulties because Grant MacEwan instructors had little understanding of where the native students were "coming from": their background, educational readiness, and adjustment problems resulting from cross-cultural stress and adaptation.

In her view, the Blue Quills Board and staff did not have a good understanding of the requirements for academic preparation for Grant MacEwan College. This led to a number of students not taking the correct prerequisites in Year 1. A number of problems within the curriculum can be traced to this basic administrative failure in communication.

Nursing practice learning experiences seem to have been ill suited to the learning objective of preparing students to work in their own communities. Experience was restricted to two urban institutions: a hospital and a geriatric home. Further difficulties resulted from poor sequencing of courses within the curriculum: the first course on arrival in Edmonton was Mental Health, which posed major academic and adjustment problems for the students. For the next group of students, Obstetrical Nursing will be first, building on the familiar knowledge-base of the student.

Although there were many problems of relating different areas of the program, there is also evidence of learning from these mistakes and adapting the program in consequence. This suggests a growing degree of relatedness as the program develops.

Accountability: The high rate of attrition at the end of Year 1 suggests that the program did not take a responsible attitude towards the needs of the students. However, this preparatory year may have served to select out those students who would not be able to complete

the rest of the course. It appears that the curriculum concentrated on teaching a narrow "medical model" of the nurse's role, which fails to convey the full sense of accountability towards a patient's needs that accompanies a more "problem-solving" approach. The disregard for learning experiences related to the real needs of the patient communities, fails to model an accountable attitude in the conduct of the program. This may be mitigated by the attitude of individual instructors, and by the initial good intentions that set the program in motion.

Oglala Sioux Community College

Relevance

This program is basically an extension program of the University of South Dakota. This means the curriculum is shaped by a body external to the community served. There is recognition of the need to fit students to work in both the native setting and the larger modern society. Courses in Indian language and culture are available in the larger College, although they are not an integral part of the nursing curriculum. The goal of offering the entire curriculum on the reservation for financial, social, and family reasons, has been met. There is some movement towards the College goal of its programs providing a bridge to the non-Indian world, when in 1981 the students had a three-week learning experience in a Denver, Colorado pediatrics hospital as well as three weeks in a mental hospital.

Consistent with most RN diploma-level programs, there is little in the curriculum of health-related learning experiences in the community. The hospital, of course, is utilized, as is the school health program to some extent.

Reflecting the poverty of South Dakota and the reservation in particular, the program operates on a shoe-string. The program was located for seven years is a cramped construction-site type of mobile trailer. The hospital reflects the low level of funding by the Federal Indian Health Bureau, but does provide the students with relevant real-life situations. The poor funding may be a threat to the viability of the program, but its establishment and survival under such conditions is evidence not only of the dedication of the staff but of real community support at the local level. The establishment of the program on the reservation under local Indian control reflects the native community's own goal of self-determination and control of their own institutions.

The courses are the usual ones found in most diploma programs, since they are determined by the University curriculum. There is an unusually heavy emphasis not only on the physical sciences but on chemistry, of which there are two courses. Because of this University affiliation, accreditation has not been a major problem; however, the "extension" of a curriculum developed elsewhere calls into question the degree of relatedness possible. Local schools as well as hospitals are being used as learning settings, suggesting an attempt to relate the curriculum to a greater variety of local needs.

Accountability:

Because the program is located in a College governed by a local community board, it has a built-in accountability to the community. Sensitivity to cross-cultural aspects of nursing do not figure prominantly in the curriculum. All but two of the graduates are

working in native communities, suggesting that students have a sense of responsibility towards native patients.

Navajo Community College

Relevance of the curriculum can be demonstrated by the proportion of Navajo knowledge-based courses, for example:

> Navajo Aspects of Maternal-Child Health Nursing: Emphasis is placed on identifying the Navajo cultural aspects surrounding pregnancy, the family's role in pregnancy and child rearing practices from infancy to two years of age. The practices are compared with, and contrasted to, those observed in other cultures. There is utilization of Navajo resource persons.
>
> Navajo Aspects of Medical Surgical Nursing of Adult and Child, II: Emphasis is placed on Navajo cultural aspects of medical-surgical patients who are children and adults. Problem-solving and total patient care incorporates the cultural attitudes important to the Navajo in his or her daily life.
>
> Navajo Aspects of Nursing in Mental Health and Illness: Explores the concept of mental health and mental illness as it is viewed in the Navajo culture. The contrast between the Navajo approach and the Western approach is analyzed. Seminars will utilize Navajo resource persons and other guest speakers.
>
> Navajo Aspects of Leadership in Nursing: Navajo cultural aspects of leadership as it applies to nursing are explored. Current trends, issues, and legislation are reviewed and their implications for the Navajo nurse discussed. Seminars and guest speakers are utilized. (Navajo College Calendar:1978)

Optional courses are available for those who speak Navajo: Navajo Winter Healing, Navajo Herbology, Navajo Basic Medical Terminology, and Navajo Ceremonies.

However, there is also a recognition of the wider cultural milieu in which the graduates must function, and the role graduates will be

able to perform in assisting their whole community in a positive adaptation to the modern world. This is expressed in the objective:

> to enhance the student's respect for her own heritage and to develop a systematic view of basic universal concepts and principles. The Navajo Nation needs professional young Navajos capable of handling the complex affairs of the modern world without ignoring the wisdom and philosophy of the Navajo's world (Navajo Calendar:1978).

A further objective of the College is "to provide a program of community service and community development," of direct relevance to community needs. Many features of the curriculum are focussed on the family and community, thereby ensuring that the student understands the social factors, problems and resources, for maintaining the healthy or nursing the ill. It is a stated goal that the student develops skills in understanding and managing the cross-cultural aspects of nursing relevant in a pluralistic society.

Relatedness:

There is evident an effort to relate different parts of the curriculum to each other (those emphasizing Navajo culture and those imparting "Western" techniques). The Navajo courses are in place to provide the students with a necessary understanding of the cultural elements in nursing. Western style health care is viewed as providing approaches that can be blended in balance or harmony with the cultural milieu in which it is set. Both cultures are appreciated as contributing to the goal of nursing human needs and health problems.

According to a Navajo nursing informant there are three major belief systems within which the people interact and blend beliefs: traditional native healing, the Native American Church, and North American Christianity. The nursing students learn value clarification

techniques for themselves and patients to sort out the ethical decision-making in various cases. The Mental Health course content utilizes the spiritual aspects of all these different belief systems.

Another advantage is that half the faculty of six nursing educators in the program are Navajo, and have Master of Nursing degrees. Their facility in both languages and cultures is a great asset in assisting Navajo students to learn the concepts of North American medical terminology.

The Board of Regents is comprised of Navajo people from the community. This makes possible a more direct influence on one another, between the community and the Board, and between the staff and the Board, than if the Board were located elsewhere. Even the architecture of the college is shaped by and responsive to the learning goals of harmony with the environment and local culture, and has been built to reflect the beliefs and daily living patterns of the Navajo.

From printed sources, the interrelatedness of curriculum, teaching, learning experiences, nursing practice, and administration is not clear. Course descriptions consistently refer to the inclusion of resource people from the community, which is one way of relating course content to the real world.

Accountability: The educational institution with its all-native Board of Regents provides a structure that is homogeneous with its surrounding communities. The evolution of Navajo-operated health agencies also provides for a smoother integration of theory with learning experiences in the community. A recent shift in the curriculum to include cultural awareness of other patient groups, such

as blacks and hispanics, reflects a continuing sense of accountability towards all patients (Phone conversation with Program Director: Feb., 1984).

The program has bases in two different communities, thereby attempting to provide more access to the program for students. As mentioned above, a high proportion of graduates (33 out of 46) are employed on the reserve.

Summary Evaluation of Cases

The following table summarizes the previous discussion; numerical values have been used to facilitate scoring, and to force a choice where precision is difficult. Two of the programs could not be evaluated as to outcomes, since they are too recent to have graduated any classes; this means the total possible score for these programs is less than for the others. For this reason the total scores are presented as a ratio of total score to possible score; this ratio is then presented as a percentage to facilitate comparison.

TABLE

	NV	IC	TH	OS	BQ	BR
Relevance						
Goals	3	3	3	2	3	2
Activities	3	3	2	2	2	2
Outcomes	2	-	-	2	2	1
Relatedness						
Curriculum	3	2	2	1	1	2
Pedagogy	3	2	2	2	2	2
Practice	3	3	2	2	2	2
Administration	3	2	3	3	2	2
Accountability	3	2	1	2	2	1
Total Score:	23/24	17/21	15/21	16/24	16/24	14/24
As Percentage:	95	81	71	67	67	58

Key: 1=low, 2=medium, 3=high
NV=Navajo, IC=Inner City, TH=Thompson, OS=Oglala Sioux, BQ=Blue Quills, BR=Brandon

Reflections and Assumptions

The problems of health care in native communities were outlined in the Introduction, and included shortages of nursing staff in the communities, nurses' education being unsuitable for nursing in northern native communities, and low recruitment of native students into regular nursing programs. The case studies demonstrate that the more community-based programs have been more effective in terms of graduating nurses who remain working in the native communities. The more institution-based programs have produced fewer graduates, and graduates who tend to remain in large hospital settings. (The outcomes of two of the programs in this regard are unknown, since they are too recent to have graduated any classes.)

These programs are providing opportunities for nursing education to people who, because of socio-cultural, academic or geographic barriers, would not have applied to, or been accepted into, regular nursing education programs. The assumptions of the planners, institutions and educators involved in these efforts are: wherever they serve as graduates, the nursing profession and clients in society have gained a valuable human resource. In Canada, the goals of our universal Medicare system — accessibility, comprehensiveness, effectiveness — will be better served by this broader participation of the population in the health service delivery system.

It is hoped that nurses whose training takes place largely within a native environment, and whose own cultural background is native, will be able to bridge the barriers to effective health care delivery created by geographic remoteness and cultural difference. Some of these nurses will provide leadership in health development in native

communities, the greatest at-risk population in Canadian society, thus contributing to improved health for this human resource and the furtherance of community development. In cases where the nursing education has taken place within native communities, the program itself may become a contribution to local community development, with a variety of spin-offs within the community.

CHAPTER V: SUMMARY, ANALYSIS AND CONCLUSIONS

Summary

In the Introduction, the thesis was advanced that community-based nursing education has advantages over institution-based education. Nursing education, implemented in cooperation with native communities and organizations is seen as a valuable means towards development of more autonomous communities. Health is the context for describing this Community Development process when applied to health delivery and nursing education.

In Chapter I, a general theoretical framework was developed, in terms of the dialectical or historical-structural paradigm. This perspective was applied to describe the power relationships between historically defined groups in North America, and to analyze the potential impact of community organization methods in developing hinterland communities to overcome their marginalization with respect to the metropolis. Community Development methodology was described as a form of action research or praxis, in which concrete cases of action inform developing knowledge through a process of reflection.

Chapter II describes the historical and structural underdevelopment of native peoples in Canada, with particular reference to developing health relationships, drawing specific examples from Northern Manitoba. Indigenous control of health service delivery and the training of native health professionals is seen as part of a strategy for more relevant health care delivery, and more effective development of community resources generally.

Chapter III examines health, health delivery and health education in various social contexts, beginning with a holistic definition of health as part of the social totality. The historical and structural development of the nursing profession and nursing education is described and analyzed as a sub-culture within dialectical relationships such as class and sex-role. Contradictions in the health care system were described, which place barriers to the delivery of health care to the community. Various proposals were discussed for more community-based health care delivery and education, leading to the development of criteria for evaluating nursing education as relevant, related and accountable.

Chapter IV describes several case studies of attempts at nursing education programs aimed at producing native nurses. The cases are classified in terms of how community-based or institution-based they are, and are evaluated in a provisional way with respect to relevance, relatedness, and accountability. There appears to be a positive correlation between effective nursing education and the community-based approach. Some incomplete attempts at community-based programs are also described, which illustrate the dialectical conflict around innovating in this direction.

In Chapter V, the extent to which the thesis has been demonstrated will be discussed, with reference to some methodological questions. The usefulness of the dialectical paradigm as a framework for understanding this type of problem will be evaluated, with particular reference to the Community Development process, and some final conclusions will be drawn.

Thesis Provisionally Demonstrated

The advantages of a community-based approach to nursing education are two-fold: as relevant, related and accountable path to educating nurses for service in northern native communities, and as a contribution to the process of development in those communities.

The convergence of several historical trends described in earlier chapters would justify a presumption that community-based nursing education would be an effective instrument for achieving both relevant nursing education and community development in northern native communities. Marginalized groups in the hinterland have had some impact on the allocation of resources and decision-making power towards their own local development through struggle with the dominant society. The trend towards institutions that express native cultural identity leads in the same direction, as does the trend towards self-determination of indigenous peoples. In the health field, a similar direction is evidenced by greater awareness of cultural dimensions of healing, critiques of the "medical model" in favour of more holistic approaches (including indigenous medicine), and suggestions for a more community-oriented approach to health care delivery in urban and rural settings. These trends are evident in such innovations as community health centres and Community Health Representatives, and various cases of nursing education programs for native people.

The indirect effects of such programs on the development of human, organizational, and material resources of the community would in itself justify this approach from a Community Development perspective. The creation of local employment (not only for graduates and teachers,

but for auxilliary personnel), the expanded administrative experience, the utilization and improvement of buildings and other physical resources, the opportunity for post-secondary education in an accessible environment, an education more relevant to the culture served, the utilization of the indigenous knowledge and skills of the community, are some of the ways in which a community-based program of nursing education can contribute to the general development of the community as a whole.

However, the implementation of nursing education programs is normally determined by other criteria, both political and professional. Where the political will is lacking, programs will not be established, or innovation will be minimal. Human service areas such as health, and more specifically nursing education, may lack sufficient priority at various levels (government departments, college administrations, tribal councils, band and community councils). This is illustrated by the difficulties in funding and implementation of some of the case examples (especially the ones not implemented at all). From a more narrow health perspective, the justification for such a program would be the demonstration that it would be a more effective approach to nursing education in terms of criteria derived from that discipline itself. The author has attempted to demonstrate such a relationship in the case study evaluation, by showing a correlation between community-based programs and relevance, relatedness and accountability. There does appear to be a positive correlation in the cases presented. The thesis is further strengthened by the more community-based programs--Navajo, Oglala Sioux--producing graduates who continue to work in native communities.

Methodological Questions

One might have proceeded in other ways. For example, the nursing criteria could have been used in a more rigorous and extensive evaluation of one case study. However, this would have yielded no comparative data, and the present approach provides useful data on the variety of programs in North America which have attempted to meet the need for producing more native nurses. This number of cases cannot be studied in such rigorous detail, but have been presented in sufficient detail to do justice to their efforts in this field. The gathering of original data on these varied programs, and their comparison in a preliminary way, is of value to the profession of nursing education, as well as to other communities which may learn from the experience of these pioneers.

One might also question the correlation between community-based programs and the nursing education criteria in terms of an implicit identity. There certainly is a sensitivity to community needs in the trend that has produced these criteria. Are the criteria of relevance, relatedness, and accountability implicitly community-based? In that case, has the author merely proved the obvious? On the contrary, what has been shown is the type of program that can fulfil these criteria. If a community-based approach is implicit in the criteria, it is nonetheless meaningful to give concrete content to the criteria in specific examples. These are particular examples of the type of program that fits the general criteria, perhaps better than other types of program. This was not assumed at the outset of the thesis, and is certainly not assumed in many quarters. If indeed an identity has been demonstrated between relevant, related, accountable

nursing education and the community-based approach, that is a worthwhile result. That would be more than this thesis claims; all that has been shown is a positive correlation.

Recommendations

The following recommendations help to draw together conclusions, observations and insights into the advantages of a community-based approach to nursing education, especially in a native context, but also more generally. Some of these recommendations flow from the general desirability of a community-based approach, and make more detailed suggestions of what that entails. Others are based on observation and discussion in the body of the thesis, especially of the case studies, and discover particular details from experience that might not otherwise be apparent.

Administration: The administration of a community-based program should be locally based, but should also be well related to the decision-making structures of the larger society. Ideally, a community-based education program should have a governing body which represents a microcosm of community interests. For example, local political, economic, schooling, and religious representation could be part of this body as well as health and service agencies, nursing school teachers and students. In a native community it would include elders and perhaps traditional medicine people as well. This would facilitate the community being a partner in the learning process, rather than an object or target. At the very least, programs based in institutions should have some sort of advisory council drawn from the community, with real in-put into the decision-making.

The introduction of a new program should be processed by and through the existing self-government structures in the communities. Implementation of plans should be flexible enough to include local designates in policy planning. Better yet, new programs should arise out of the expressed needs of the local community, in response to representations from their own decision-making bodies. In all cases, administration should be sensitive to local community bodies, including staff and students.

However, a program with considerable "grass-roots" support may still be hampered by difficult relations with larger institutions which control funding and other areas of decision-making. The Oglala Sioux program was an example of an under-funded program which managed to survive by local interest and staff dedication. Other programs experience some difficulties dealing with distant bureaucracies, such as the Thompson example, leading to the recommendation of more autonomous, local administration. In some cases, conflict between different parts of the larger institutional structure may contribute to cancellation of a program, as in The Pas. In other cases, the cooperation of administrators with a desire to see a successful program implemented may facilitate rapid implemenatation of a program (although running the danger of imposition from without) as in the Winnipeg Inner City example. Thus, while locally based administration is vital, a supportive attitude from larger institutions is an asset.

Curriculum, Pedagogy and Practice: The curriculum, teaching methods, and learning experiences, should all be shaped by the needs and resources of the local community. Borrowing a curriculum that has been written for and shaped by a different type of community or

institutional setting is the antithesis of this. While certain basics must be covered, in keeping with standards set for RN exams, for example, this can be done in an imaginative way that fully integrates these basic requirements into the local conditions. Even in the case of borrowed curricula, much can be done through teaching style, selection of local learning experiences, and use of local resource people, to re-make the curriculum towards more relevant content.

The dialectical paradigm challenges a nursing education program to develop a pedagogy which involves the teachers and students together in a learning process which focuses on problems not as static situations but as results of historically created events. These evolving situations can be analyzed in terms of the particular actors and interests they represent and embody in their actions. Problem situations can be viewed in their totality and the contradictions described. This learning process is itself action research, and achieves a degree of participation and collaboration that would not be as evident in a more conventional institutionalized education program. Teacher and students should be involved in an interaction of praxis with the roots of health problems in all their social complexity. This implies learning institutions that are much more closely related to the community, and in particular to native communities, than has been the case.

The personnel training function must be integrated into the health care services so that dynamic, relevant instruction will be offered. Teaching staff should cooperate with staff of local health agencies in designing and selecting learning experiences. One way of facilitating this is through joint appointments between educational and health

agencies. Local resource people, both professionals and traditional healers, should be drawn upon. Oral teaching by selected elders, medicine people, and other community resource people, should be encouraged in the curriculum to facilitate increased attention to Indian culture, life, and customs. To broaden the horizon and encourage the perception of the inter-relatedness of health strengths and problems, instruction and practice should include all types of "patient": the community as a whole and the larger political structures it relates to, groups with common needs and problems, families, and individuals. Substantial content should be related to health maintenance, including mental health, management of chronic illness and health education strategies and techniques. The educational process should take into account the resources available in the traditional community system. Health education, and in particular nursing education, must reflect the total context in the content of curriculum and in teaching methods.

Community practice learning experiences should be planned to occur early in the program. Revisions of curricula should give special importance to practice in and early exposure to the community, as well as foster the growth of a critical and creative awareness that produces workers that can "take on" new functions consistent with changing conditions. For students to learn this total context of health, a much more varied practice in a number of community settings is required. The most relevant learning experiences will be in the communities the graduates are to serve. This implies locating the instruction facilities as close as possible to the local community, and building in time for local learning experiences.

Attention should be given in the curriculum to native culture, but also to cross-cultural situations. This is best illustrated by the Navajo example, which began by integrating native cultural content into the course content, but later developed units on other cultures. Such courses could include communication skills, an appreciation of oneself and others, and sensitivity to cross-cultural differences. This has further implications for the location of learning practice. There are a great variety of locations in northern Manitoba, for example, with healing institutions of varying size and scope, representing great cultural diversity (Cree, Inuit, Chipewayan, Metis, British, Ukrainian). However, the typical native patient experience includes the trip to a large metropolitan hospital in the south, and the "high tech" approach to medical care. It would be appropriate for students to have some exposure to this environment in a supervised experience, perhaps as a "follow-through" experience in which the nursing student accompanies the patient through the different stages of such a journey.

Selection: Selection of students should be done in cooperation with the communities. Ideally, communities could recommend selected students to the program. Criteria for selection should include other factors than academic qualification, such as interest and motivation in caring for people, sensitivity to cultural factors, and desire to contribute to the development of their community. In the Manitoba examples, affirmative action criteria were employed to ensure the availability of programs to those disadvantaged by geographic, academic, ethnic or financial barriers, and funding and other support services were provided as needed. The American examples placed an

additional hurdle in the path of disadvantaged students by requiring high school standing before entrance. In all the Canadian examples, academic up-grading is provided within the curriculum, usually as a preliminary section prior to actual nursing studies. It would be more sound pedagogically to integrate up-grading of such skills as literacy and study-habits into the rest of the curriculum. This would introduce the students more immediately to some nursing content and experience, and motivate them to learn the other skills in the process. However, this does not easily fit in to the usual division of labour amongst staff.

Staff: In many cases, leadership and innovation comes from dedicated teaching staff who are close to the needs of the community and convinced of the importance of community content in their teaching style, selection of learning experiences, and general attitude to students and patients. This stands out in the Winnipeg Inner City, Thompson, and Oglala Sioux and Navajo examples. In the Winnipeg and Thompson cases, the recruitment of qualified teachers of native ancestry is a rare and valuable asset, and contributes to overcoming other factors in these programs (borrowed curriculum, institutional based administration). In the real world, it is more important to have an imperfect program than no program at all. In many cases, programs were initiated in some haste because of the urgency of the need, and have moved towards a more community-based format through the praxis of reflecting on a program already in process. These are genuine examples of gradualist reform creating new possibilities, rather than merely band-aid solutions disguising the problem.

Reflection on the Dialectical Paradigm

Native society and the health system have been presented in the larger theoretical framework of the dialectical paradigm. It is significant to reflect on the usefulness of this framework for understanding the subject matter presented, for such utility is a form of verification for the paradigm itself. In this sense, every concrete act of research contributes to the production of theory at the more reflective level.

Social Construction: Social structures are not merely given, they are produced and modified by society by the changing power relations of various groups. This thesis has described the current struggles of marginal societies to construct social arrangements that will serve their own needs better than the structures provided by the metropolitan society.

The existing social structures of native peoples are largely the constructions of the dominant society, which historically has undermined, repressed, and outlawed traditional native social structures, and imposed its own structures in their place. In reaction to this loss of self-determination, native people are now seeking control of their own institutions, and the formation of their own institutions to meet their own needs. Because their power-base is largely local, much of the struggle is for local control. The development of local health delivery and education structures are part of this process. The restructuring of male-female roles is another dynamic affecting the processes of decision-making within native communities, as well as in the larger society and its institutions.

The application of this paradigm to my own situation leads me to make some further reflections: The Pas Band and indeed many native groups are in the midst of a process of structuring their own institutions, on a separate basis from the surrounding dominant society. This activity appears to be happening as a result of having their own institutional development interrupted or suppressed through imposition of alien institutional forms by a dominant and dominating cultural group. Priorities appear to be in the political, economic, and basic schooling realms on The Pas Reserve. It takes concrete form in building projects such as the retail and office Mall, a Home for Elders in need of healthcare, an Arena, and in current plans for a new church building, school, and hotel. These forms have been adopted from the modern, dominant society and adapted through local administrative styles.

In the health services area, the Band wants total budgetary and administrative control at the local level, as well as more accessible on-reserve services -- mental health counselling, physician, dental, as well as the current alcohol counselling and nursing services. This Band is resistant to establishing any bureaucracy higher than itself in power or authority. For example, The Swampy Cree Tribal Council is only to provide coordination and advisory services. Higher levels of native organization are stabilizing after a process of critique and disintegration. Twenty-six northern bands split from the previous provincial-level organization because they believed the southern, urban-oriented organization was not accountable enough to the Band level. The northern group is called Manitoba Keewatinowi Okemakanac (MKO). The issue of community-based nursing education seems to be a

higher priority of the more remote bands where turnover of nursing personnel is greater, and there is no immediate access to other health services such as the Town facilities in The Pas.

Totality: Particular parts of the social structure exist in a dynamic relationship to the whole, and cannot be viewed in isolation. Trends that are evident in one aspect of society also appear in other fields, on other time-tables. This produces convergence between trends in various fields, but also contradictions between fields that are progressing at a different pace. This was noted, for example, in the historical development of nursing education.

The concept of totality was applied to the discussion of health context in native communities. Health was defined holistically in relationship to the total social reality. Health in native communities (and all communities) is a dimension of every problem and solution, and every other dimension of communal life also impinges on health. Community Development approaches to health delivery and nursing education are part of an over-all strategy for producing healthier communities. The content of nursing education must include the broad social context within which health is one dimension.

Some nursing education cases have demonstrated an awareness of the larger totality by providing learning experiences in a variety of settings beyond the hospital. Whether the students are being challenged to "problematize" with the "patient" is unknown, but the provision of the broader experience will, at the minimum, stimulate students to make observations of the larger totality.

However, the local community and its structures also exist within the larger totality of the whole society. This is expressed in the

metropolitan-hinterland relationships and the struggle to correct the resultant underdevelopment. Changes in health delivery and nursing education at the local level cannot be made without reference to the institutions of governments, colleges, hospitals and professional associations. These structures may obstruct development or they may facilitate it, but they must in either case be dealt with.

Contradiction: Changes in the social structure are brought about as a result of tensions between different groups, and inconsistencies in the previous resolution of those tensions. The road to development will often be a bumpy one, with set-backs along the way.

Even in the dominant society, the contradiction between native poverty and the top-heavy bureaucracy of the Departments of Indian Affairs and Health and Welfare produces an awareness of the need for change. However, different interests are in conflict when such social realities are challenged.

This is evident in the discussion of the failure to implement some innovative programs in northern Manitoba. The interest-groups in conflict included native communities, white communities, the local hospitals and their staff, the community college and its staff, existing health professions, and the Provincial bureaucracy. Contradiction between these groups was sharpened to the point that it became politically counter-productive, and destroyed the potential program.

Praxis: Change takes place through a cycle of reflection and action; learning is a result of reflection on intentional action, and issues in further action.

This is the shape this thesis has taken. A theoretical view of social reality was presented, itself the result of previous action/reflection by social researchers interested in social change. The role of the Community Development agent or community organizer was outlined against this background. Experience from the history of native people struggling for self-determination, and from developments in nursing and nursing education was reflected on. Case studies were described in some detail as concrete actions to bring about desired change, and that experience reflected on. The direct experience of the author was also drawn on for additional insight.

The reflection that goes on amongst social researchers or health educators is a social praxis, taking place within a community of scholars with a common discipline, shared literature, and in some cases shared goals. This is particularly true of those engaged in Community Development, whose practical thrust sends the practitioner into the field to put theory into practice, and to test theory against practice, in a community of discourse amongst fellow-practitioners. However, the most important community within which praxis must take place is the local community. It is in the process of evaluation by each case history's sponsoring community that the most important learning goes on. If real development is to take place, praxis must happen at the "grass roots" in a self-aware community that remembers, discusses, and plans together. The task of the community development worker is not to develop theory in the community of scholars, but to

enable local communities to engage in this praxis of action and reflection.

The Role of the Community Development Agent

The conditions for social change are socially produced through contradiction. However, for creative social change to take place, the role of individuals is significant. Contradiction can degenerate into destructive conflict if it is mis-managed. In the example of the aborted program proposal at KCC, a different outcome might have resulted if different leadership had been exercised at the administrative level. Instead, leadership either exacerbated conflict or avoided conflict. Different leadership styles might have sought and found a compromise that could reconcile the different needs of different interest groups.

In the organizational structure, the author was not powerfully placed to act in such a leadership capacity. As an agent of change, she was dependent on the power of others to support the general direction of desired change. Those in positions of administrative power were either hostile to, or indifferent to, the implementation of the program as conceived. The native communities, on the other hand, were not effectively organized around this issue, did not make it a high enough priority to reverse the situation, and accepted the less community-based alternative of the Thompson program.

A similar lesson emerges from the history of the community development program initiated by Indian Affairs in the early 1960s:

> However, despite, or because of, its early successes the program disintegrated in a welter of bureaucratic infighting and conflicts among the community development staff, Indian agents, senior bureaucrats, and factions in the Indian communities. The community development staff, torn between loyalty to their employer and to the Indian people, frequently found themselves as partisans on the side of the Indians against the government, and as such their support and effectiveness within the Indian Affairs bureaucracy rapidly dissipated. Concluding that the community development program threw sand in the gears of efficient administration, (Indian Affairs) moved to terminate the program (Gibbins and Ponting: 1980:21).

To bring about change effectively, then, the Community Development agent must have a power base that can withstand the conflict implicit in contradiction. It is helpful if that power is supported by the larger structures of society; it is essential, that it be rooted in the determined support of the community.

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